the Canadian Nurse

VOLUME 60 • NUMBER 7

MONTREAL

JULY 1964

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Between Ourselves

Four years ago, the Journal Board decided that we should discontinue the time-honored practice of publishing reports of the annual conventions held by the provincial nurses' associations. Instead, each year we have noted the highlights of provincial activity as reported to the CNA Executive Committee by the ten executive secretaries.

This month, however, we have deviated from that pattern by including a report of the 1964 convention of the Registered Nurses' Association of Ontario. Over the past several months some newspapers and periodicals have given considerable space in their columns to a splinter group organized in Toronto. This group protested volubly about many aspects of the professional organization's activity and agitated for many changes. To meet these challenges, the Board of Directors of the RNAO hired a fact-finding firm to look into the situation. Were the splinter group right? Was there such a strong undercurrent of disapproval that some drastic form of reorganization might be necessary? Was the staff nurse as neglected as it seemed?

Two of the Journal's editorial staff have prepared a report of the convention so that all of the nurses in Canada may be aware of the tides of change. With so much explosive unrest in so many countries, it is not strange that an echo of it should be found among the members of our profession. Keep this in mind as you read the report written by JEAN MACGREGOR and VIRGINIA LINDABURY of the Journal's editorial staff, as you read the address given by DR. MURIEL UPRICHARD. Far-reaching plans approved by the convention body in Ontario will have repercussions in many other areas. Follow these developments through the pages of your *Journal*.

In a different setting — at the annual meeting of the Canadian Catholic Conference of Schools of Nursing — DR. OSWALD HALL gave the address on "Problems Affecting the Nurse's Status." His remarks underline again some of the causative factors in the current unrest. Dr. Hall makes some suggestions regarding where staff nurses might hope to secure support and understanding in their present dilemma.

For many years, the July issues have included the prize-winning comprehensive nursing care studies written by student nurses for the Macmillan Award Competition. The limitations of space have prevented us from publishing here all of the papers of this year's winners. Others will appear in subsequent editions.

* * *

We had hoped that some at least of the CNA convention addresses would be available this month. Unhappily, the time factor has worked against this plan. In order to edit, translate, print and prepare for distribution some 67,000 copies of *The Canadian Nurse* and some 13,000 copies of *L'Infirmière Canadienne*, it was necessary to close this issue on the fifteenth of May. None of the convention addresses was available by that date, We shall bring them to you in successive issues beginning next month, we hope. Our story of the convention will be featured in the September issue.

* * *

Space limitations have required us to make another change in editorial content. When 42 "In Memoriam" items were received in one recent month, our editorial staff decided we had no choice but to curtail the data customarily included in these write-ups. In the abbreviated form, we shall continue to pay tribute to our departed colleagues. The new form will appear in next month's issue.

A perfectionist is a person who chooses a picnic site as carefully as he would a permanent home.

* * *

Life does not consist of everyone living in his own little corner. There needs to be contact between people, not merely bodies pushing one another through a revolving door, but mental and spiritual exchange of ideas.

The Royal Bank of Canada Monthly Letter, April, 1964.

* * *

I had rather wear out than rust out.

GEORGE WHITEFIELD

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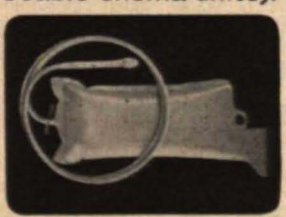

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Random Comments

Dear Editor:

I find the *Journal* very educational and of great interest. It is especially helpful for those of us who either do part-time nursing or who do not practise at all.

We are forever hearing the cry "Where are our future nurses coming from?" I have taken the liberty of sending you a picture of a possible candidate. She is my 3½ yr. old daughter Diane who is very proud of her cap and uniform. I would be exceedingly proud if she does choose our profession some day.

Catherine Latham, Ont.

DIANE LATHAM

Dear Editor:

We feel that nurses should be persuaded that synthetic uniforms are not suitable for hospital wear. Nylons and similar fabrics are not laundered in hospital laundries and must, therefore, be washed at home.

According to our Infection Committee, this laundering at low heat with little ironing is not sufficient to rid the garment of bacteria — consequently organisms accumulate. I feel our national magazine should refrain from advertising synthetic uniforms and should publicize the danger of infection when such uniforms are worn.

Helen M. King, Director of Nursing, Vancouver General Hospital, B.C.

Dear Editor:

Of all the disgusting, presumptous nonsense that I have ever read, your "Hymn to to the Welfare State" (In a Capsule, April,

1964) is the very end. It is sacrilegious and in poor taste, to say the least. Since when do you presume to do the thinking for your subscribers?

I suppose this poem represents your opinion of socialized medicine. It seems to me that the Florence Nightingale tradition prevents nurses from involving themselves in politics, a matter of which very few have ever displayed any great knowledge, at least publicly. Most do not even attend the conferences at which their leaders are selected; thus, leadership falls into the hands of a small group of people whose motives I question and whose legislation reflects their desires or opinions.

A very good illustration is the wishy-washy approach to increasing nurses' salaries. In order to make a decent living, a nurse has to go to the United States. Of course hospitals maintain a supply of married women. How convenient! They do not require a high salary since their's represents the second cheque. The young lady who chooses nursing as a full-time career must either work her way up quickly into a supervisory position with better pay or be satisfied with a relatively low salary and allow the government and other employers to cash in on her dedication.

Governments, in holding down the cost of maintaining hospitals, invariably economize by holding the line on nurses' salaries. One might say the nursing organizations in Canada are subsidizing the government in this field. We certainly cannot call that a "welfare state." You have a nerve to criticize the welfare state in spite of the fact that, as a private enterprise, the nursing profession is a deplorable failure.

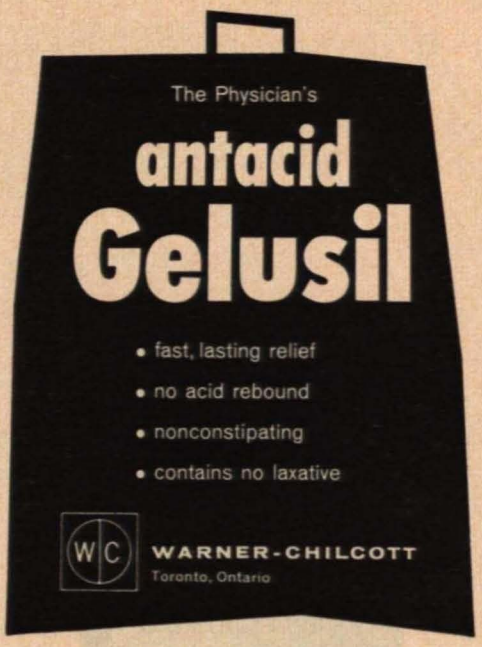
O. A. Olson, Manitoba

Dear Editor:

The doctors are up to something. Have you noticed?

The sight of Dr. B. *chewing gum* was the first I knew of it. He wore a look of grim determination. Close behind him came several others, sharing a joke among themselves, and centering around Dr. R. — who had an unaccustomed pipe in his mouth.

The doctors are giving up — or cutting down on — smoking. At a seminar held in our hospital, only three out of 27 were smoking. Cancer propaganda is partly responsible, of course. The prevalence of emphysema is also alarming. It isn't a pleasant sight to watch a patient gasping his life away, his suffering increased by every puff



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of a forbidden cigarette. So now the medical profession is trying to practise what it preaches.

Nurses, too, profess to be teachers of health. At a recent meeting we were requested not to smoke, with the remark that it would be ironic for a professional meeting-place to be the last stronghold of smoking. The expressions on the faces of inveterate tobacco addicts changed from dismay to good-natured laughter at their own expense.

If the doctors can do it, so can we! Let's get behind our medical men in a good cause.

(Mrs.) Margaret Minchin, B.C.

Dear Editor:

I would like to reply to Mrs. De Witt's comments concerning male nurses (Mar. '64).

The male nurse should be admired for attempting to help meet the nursing shortage even though he knows that many persons will view him with prejudice of this sort.

Mrs. De Witt suggests that the male nurse confine himself to caring for patients with urological disorders and V.D. I was not aware that urological disorders and venereal diseases were peculiar to men; in Manitoba, we have female patients with both of these diseases.

The male nurse is obviously not induced into nursing by the financial remuneration. His salary is insufficient to permit him to support a family, pay for a home, etc. Thus, he frequently accepts administrative or supervisory positions where the salary is higher.

Now a hospital supervisor — whether male or female — must have a knowledge of *all* services (including obstetrics and gynecology.) Obviously this can only be obtained by teaching and experience in these departments. It would look rather silly if a supervisor, called to an obstetrical unit because a patient was hemorrhaging, was unable to deal intelligently with the situation.

"What woman in labor would want a male nurse caring for her?" queries Mrs. De Witt. I have had four weeks experience in the labor room, and have never encountered prejudice from a female *patient*. I gained a broader understanding of patient care, as a result of this experience. I also feel that it will help me to be more understanding in the future, when I marry and have a family.

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To the nurses who are prejudiced, I ask: Should we leave the classroom when female anatomy and diseases are taught in our anatomy, medical and surgical classes? Remember, we know how it is to be embarrassed and will do all in our power not to make our patients feel uncomfortable because we are of the opposite sex.

Walter Bohonis, R.N., Manitoba

Dear Editor:

The Canadian Nurse is doing a fine job of introducing Canadian nurses to each other and to themselves. There are many of us who are bewildered by the ever-changing world of nursing. We know how we feel but wonder where our place is in the new scheme of things. Thank you for being our sounding board.

The enclosed lines were written during an illness. Although brief, it was long enough for me to feel the desperate need for a medication science could not supply. There were several nurses whose hands always offered kindness. At the time I felt guilty that I should take so much and give so little, but on returning to nursing again, I discovered an answer I had never recognized before. Kindness returns as it is given. Even as I am now giving to the patient and she is being healed, so also am I being healed by the return flow.

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And gives to me the strength I need.
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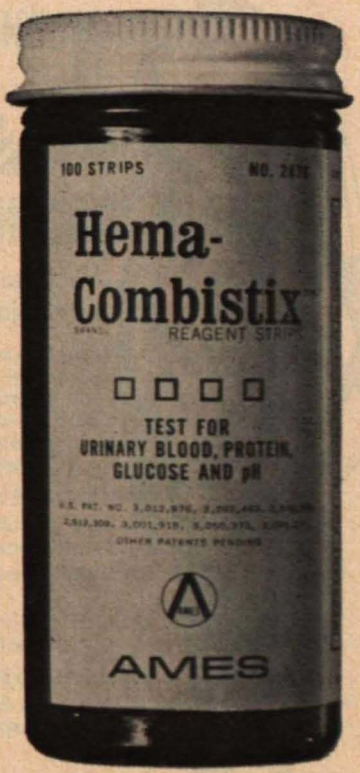
Science with its modern magic ways
Has renewed my sickened frame;
But it is my nurse's gentle hands
That heal, as the Samaritan, the maim.

Down through the centuries of pain
Kind hands have passed the gift along;
Not because of law or pious creed
But as the bird, his lilting song.

Transfusions run from her to me
Each time her soothing hands are near.
Does she miss the healing stream?
Does she feel it go, then reappear?

Is this the miracle of God's love
A healing gift from hand to heart,
That understands the need within
And gives to each another start?

(Mrs.) Margaret Snyder, Ont.



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By *Thelma Pelley*, R.N., Formerly Instructor in Nursing, General Hospital of Port Arthur, Port Arthur, Ontario. About 205 pages, 5⅛" x 7⅛". About $4.00.
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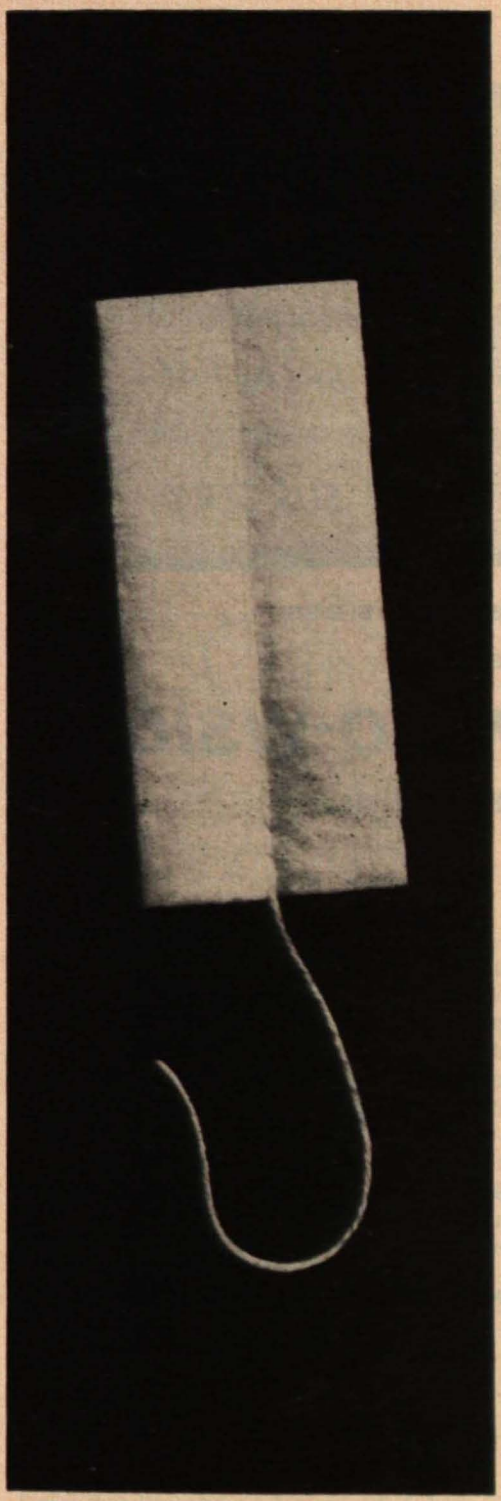

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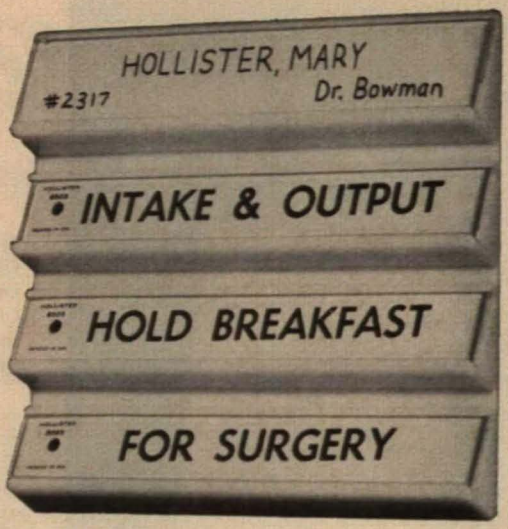

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THE CANADIAN NURSE

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BY THE CANADIAN NURSES' ASSOCIATION

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Our New Leader

The two most essential characteristics of the person chosen to head any organization are: ability to preside efficiently; and an indisputable ability to lead. The rules of parliamentary procedure provide an adequate framework through which the will of the majority can be determined democractically. However, since carrying out these decisions calls for a high degree of human collaboration, the leader should realize that logic, arguments and facts must often be adjusted to the consideration of individual sentiments, prejudices and traditions. So, in striving to reach a satisfactory collective goal, the capable president never loses sight of individuals — their hopes, fears and relationships.

Such a leader is our new president, ANN ISOBEL (BLACK) MACLEOD. Thoughtful, considerate, an excellent listener who is capable of coordinating conflicting points of view and assessing the details of perplexing problems quickly, Mrs. MacLeod brings to her new responsibilities a broad variety of experience that will be a strength to the whole Canadian Nurses' Association.

(Gaby, Montreal)

ISOBEL MACLEOD

The eldest of three children of the Rev. A. E. and Mrs. Black, Isobel was born at Sturgeon Falls, Ontario on June 24. Her preliminary education was completed in Ontario before her family moved to Edmonton, Alberta, where she enrolled in the degree course in nursing at the University of Alberta. She chose the public health nursing option for her final year, taking this course, through affiliation, at the University of British Columbia in Vancouver. A six-week assignment in a northerly settlement in Alberta persuaded Isobel that she would rather work as a member of a city staff than struggle alone with a wood stove, that smoked constantly, on which she was supposed to cook her meals! Perhaps a recollection of that difficulty persuaded her to enrol for supplementary courses in cookery, while she was securing her master's degree in nursing education at Teachers College, New York!

Joining the Winnipeg District of the Victorian Order of Nurses in 1936, Miss Black served a number of years with that organization, working also in Victoria and Hamilton before being assigned to initiate a new branch at Niagara Falls. She was health instructor at the Winnipeg General Hospital for two years before becoming a member of the faculty of the new School of Nursing opened at the University of Manitoba in 1944. There, she gave lectures in public health nursing. Three years later she was invited to become assistant superintendent of the Victorian Order of Nurses for Canada in Ottawa. In 1949 Miss Black transferred to the district superintendency in the Greater Montreal branch. She assumed her present position as director of nursing and principal of the school of nursing at The Montreal General Hospital in 1953. Her marriage to Dr. A. W. MacLeod took place the following year.

The first married nurse to be president of our Association since Mrs. Scharley Brown of British Columbia, 1914-17, Mrs. MacLeod has been a convincing speaker in numerous professional panel discussions, served on many committees both nationally and provincially, been chairman of the Journal Board for four years, and during the past biennium had an opportunity to become deeply immersed in CNA affairs as our first vice-president. All of this, added to preoccupation with a full-time, many-sided job, provides what many might regard as an overwhelming load. Yet so well planned is Mrs. MacLeod's life that she and her husband find time for many relaxing interests — skiing in the Laurentians or Vermont or Switzerland; swimming in the crystal clear waters off a Caribbean island or in a lake in Ireland; horseback riding; shooting rolls of film as they travel; evenings spent in reading, enjoying good music, relaxing at a movie. Truly, our new president is a woman of many parts, an able, kindly leader.

We salute you, Madame President.

M. E.K.

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The RNAO in 1964

A brief report of action at their convention.

"It is important to bring about change objectively by evolution, not by revolution—and in a friendly manner. No one group is *all* right or *all* wrong." These words were spoken by the Minister of Health for Ontario, the HONORABLE MATTHEW B. DYMOND in his brief address to members of the Registered Nurses' Association of Ontario at their annual meeting, April, 1964.

The groups which Dr. Dymond referred to in his address were the RNAO and "The Committee for the Advancement of Professional Nurses" (CAPN) — a committee organized earlier this year to "seek changes within the RNAO." CAPN has received considerable publicity in the daily press and in other publications.

KEYNOTE ADDRESS

In her report, the RNAO president JENNY M. WEIR stated:

It has been no surprise to find [in the province-wide study of attitudes of registered nurses in Ontario] that there is great dissatisfaction. It has been no surprise to find that to some extent the RNAO is being used as a scapegoat, as a target for expressing frustration.

. . . The frustrations of the nurse do not stem from a single cause. Our role is changing and the growing complexity of health services is rushing this. We are no longer a largely self-employed group; specialization is occurring within our profession; knowledge in the behavioral sciences has made us doubt some of our traditional practices. The complex treatment centres have become impersonal institutions subject to the same problems that big business has been dealing with for years.

GRUNEAU REPORT

As a result of persistent criticism in the press directed against the Association, the Board of Directors decided to retain an independent opinion research organization to conduct a "thorough and representative study of the attitudes of the registered nurses in Ontario in specific regard to their professional organization." The findings of this study were presented at the meeting by DR. GRUNEAU, head of the organization that conducted the study.

New RNAO President MRS. MARGARET R. PAGE *(L) and guest speaker* DR. MURIEL UPRICHARD.

Many nurses stated that they entered nursing for altruistic reasons — to help others. This altruism was, nevertheless, tinged in many instances with a certain amount of materialism: "People look up to nurses and it seemed like a good way to make a living . . . ." Thus, while altruism motivates many nurses, the assumption cannot be made that the dedication to this mission is so deep that other rewards are of little significance.

While the vast majority of nurses find their work rewarding, a large proportion (75%) find that their work is also laden with many frustrations. The staff nurse is somewhat more concerned with long hours and poor pay, and not enough time for proper patient care, while her supervisor

finds more frustrations in poor organization, and poor communications with staff and doctors.

The conditions which nurses think require immediate action are: 1. Their work loads; 2. the fact that they have no opportunity to state grievances; 3. patient care standards are not high enough. The contention that these conditions present frustrations to all or most nurses (as recent publicity has claimed) does not appear to be true. It is interesting to note that the part-time nurses expressed most concern about the work load. Only about 20 per cent of the nurses felt that the work load problem was primarily a responsibility of the RNAO.

The employer-employee relationship gave the impression that it lagged many years behind the more regularized and "benevolent" relationships which have developed in industry. Fifty-five per cent of nurses interviewed felt that the RNAO should take leadership in the "grievance area."

Respondents who considered themselves members of the RNAO were asked: "Why do you belong to the RNAO?" Approximately one-third of *all* nurses interviewed replied that they thought it was required or that employers requested it. Whereas 43 per cent of the general duty nurses and 42 per cent of the part-time nurses felt this way, only 18 per cent of the nursing heads and supervisors belonged to the Association for this reason.

Answers to the question: "What do you personally, think should be the objectives of the RNAO?" showed a sharp difference between attitudes held by the general duty nurse and those held by her supervisor. The staff nurse is much more concerned with RNAO objectives in the area of salary increases than her supervisor and she is less concerned about the more altruistic objectives, such as "advancing the interests of the profession" and "raising standards."

Respondents were asked to describe the extent of their contact with the RNAO in terms of whether they had attended local or other meetings, served on committees, etc. The data show very clearly that the nursing supervisor or director has had far more involvement with the RNAO than has the staff nurse. The nurse who works part-time has had the least involvement. This is not necessarily the RNAO's fault. The part-time general duty nurse splits her interest between her job and (in most cases) her family. She has less inclination to spend the time to get involved in RNAO affairs and is inclined to criticize without contributing. Seventy-three per cent of nurses who work part-time said they would not be interested in devoting any time to the association; seventy-six per cent of the staff nurses also denied any interest in getting involved.

Findings indicated that the staff nurse is considerably more critical of the RNAO than is the nursing director or supervisor; nurses who work part-time are most critical of all.

HONORARY MEMBERSHIPS

In recognition of their distinguished service to nursing in Ontario, *honorary life membership* was conferred upon:

Miss BEATRICE ELLIS, former director of nursing and principal of the school of the Toronto Western Hospital, and at one time, secretary of the Graduate Nurses' Association of Ontario.

Miss FLORENCE H. M. EMORY, Professor Emeritus, School of Nursing, University of Toronto and first president of the RNAO.

Miss MATILDA FITZGERALD, the first secretary-treasurer of the RNAO.

Miss MARY B. MILLMAN, former professor of nursing, School of Nursing, University of Toronto and third president of the RNAO.

Miss FLORENCE H. WALKER, former secretary-treasurer of the RNAO.

Honorary membership was conferred upon:

Miss MARY E. JAMES for her quality reporting of nursing affairs as a writer for the *Globe and Mail.*

DR. KENNETH G. GRAY, legal adviser to the RNAO.

PROVINCE-WIDE STUDY

At the 1963 annual meeting it was resolved that a province-wide study of nursing should be undertaken "in which the beliefs and responsibilities of nursing will be identified and supported by the members of the RNAO and subsequently interpreted to the allied health groups." The decision was taken as a result of concern related to: provision of nursing; trends indicated in briefs presented to the Royal Commission on Health Services; the need to determine if the RNAO was speaking for nursing within the province; the need for concrete

action by nurses in managing their own affairs.

This was not intended as a scientific study of nursing but it was hoped to secure as broad an expression of opinion from the membership as possible. It was conducted through study groups at chapter and district levels supplemented by a questionnaire early this year. As of mid-March 2,278 responses to the latter had been received. A panel chaired by MARGARET MORGAN presented a verbal interim report indicating progress to date and marking the completion of the first phase of the study. A written report of Phase 1 will be submitted to the RNAO Board of Directors this fall after final compilation of data. Panel members presented a sampling of opinion under the general headings: What is nursing; role relationships; working conditions; basic nursing education; continuing education; the RNAO:

The variety of opinions and beliefs expressed as to what nursing is, ruled out an all-inclusive definition. Certain definite beliefs could be arrived at, e.g. that nursing is a personal service, involving physical, emotional, social and spiritual aspects, that assists in attainment and maintenance of a certain level of health. On the negative side, lack of cooperation and communication in the work situation; discrepancy between the philosophy of the agency and the care that nurses desire to give, were cited.

Opinions related to working conditions threw her relationship with the registered nursing assistant into sharp relief — the feeling that she is being superseded by the nursing assistant at the bedside. There was concern about the burden of non-nursing duties and their tendency to make nursing a non-definable profession. Horizontal promotion of bedside nurses would contribute to satisfaction. There was some ambivalence of feeling concerning team nursing: some considered the present pattern good; others suggested need for good administration for greatest effectiveness; still others commented on the need to give the team leader more responsibility. In general, communication at all levels and between all categories of personnel need improvement.

Opinions concerning the nurse's role included the need for recognition of experience, extra preparation, ability; the need for a shift differential and extra remuneration in specialized areas; the lack of job descriptions; the need for participation of all personnel in rotation schedules; the need for auxiliaries to relieve the nurse from non-nursing duties; the need for an opportunity to perform creatively; the need for evaluation reports indicating good as well as poor work; the need for collective bargaining and a chance to air grievances.

Comments related to educational preparation of nurses varied widely as to suggested patterns but the underlying consensus was that whatever the system it should allow the graduate to proceed on to higher education. It was felt that a conflict does exist between education and service; that this is illogical since both are directed towards care of the patient. Better methods for assessing individual proficiency are required. Psychiatric experience has become a necessity; general programs are too academic and students are not prepared to give good care.

There appeared to be general agreement on the value of continuing education. It adds to job satisfaction, develops individual potentiality. Considerable emphasis was placed on inservice education. The opportunity for specialization was considered important as well.

Comments concerning the RNAO touched upon need for revision in structure; more adequate representation at the staff nurse level; collective bargaining power.

An address by DR. MURIEL UPRICHARD, School of Nursing, University of Toronto, followed the presentation. Dr. Uprichard's remarks were based on the data arising out of the province-wide study as compiled to date. Her address can be found on page 647.

An informal presentation related to collective bargaining was conducted by DR. JOHN CRISPO, Assistant Professor, School of Business, University of Toronto and Mr. GEORGE FERGUSON, Queen's Counsel, of the firm Ferguson, Montgomery, Cassels and Mitchell, Toronto. The significant conclusions to be drawn from their remarks were: The urgent need for the RNAO to take the initiative in establishing itself as a bargaining agent before the opportunity was lost; the need for unity among the members and the detrimental effect of personal animosities in seeking legislative ac-

tion; the advisability of using collective bargaining — that it is, in effect, unprofessional not to do so.

The closing session of the convention was devoted to voting on the very extensive list of resolutions submitted to and presented by the Resolutions Committee. The following summary indicates resolutions duly carried and of particular significance to the work of the association:

That the RNAO should seek legislation granting collective bargaining power to it; that the Board of Directors of the Association should establish an Interim Committee on collective bargaining as soon as possible with membership drawn on a proportionate basis from the various ranks likely to be affected by the program; that steps should be taken immediately to employ an industrial relations specialist who would assist with all the details relevant to establishment and implementation of a collective bargaining program.

That consideration should be given to holding the RNAO annual meeting in different areas within the province in coming years with Port Arthur as the centre for 1965.

That an intensive recruitment program should be instituted for the purpose of increasing RNAO membership to 95-100 per cent.

That the possibility of developing a student nurses' organization within the province should be considered.

That a referendum be conducted during the coming year to ascertain the beliefs of Ontario nurses regarding shift differential; the results to be incorporated "into the statement of General Policies in the Personnel Policies."

Installation of officers for the year 1964-65 concluded a very busy annual meeting. MRS. MARGARET R. PAGE, a graduate of Victoria Hospital, London, Ont., and presently supervisor of public health nursing, Port Arthur and District Health Unit, is the new president. E. MARIE SEWELL, a graduate of Wellesley Hospital, Toronto and presently assistant director, nursing education, New Mount Sinai Hospital, Toronto was elected first vice-president while ELSBETH GEIGER, director of nursing, Hospital for Sick Children, Toronto and a graduate of Royal Victoria Hospital, Montreal became second vice-president.

J.E.M. & V.A.L.

PATENT DUCTUS ARTERIOSUS

Oxygen pressure in the blood is the "switch" that changes the circulatory patterns in babies within minutes after they take their first breath. As a result of this finding, a way may eventually be found to treat, without surgery, one of the most common inborn heart defects, *patent ductus arteriosus*.

As normal infants begin to breathe, more and more oxygen is absorbed into the blood stream and O_2 pressure rises. When a critical pressure is reached, the ductus shuts. Generally, closure takes place within the first half hour after birth. After a time in certain cases, the ductus loses its sensitivity to O_2 and does not respond to elevated pressures.

Any condition that prevents the newborn's lungs from being exposed to sufficient amounts of oxygen may interfere with closure. Thus premature babies, whose lungs are not fully developed, are particularly prone; so too are children born in the Peruvian Andes at altitudes of 16,000 feet or more where the air is extremely thin (oxygen-poor). With the normal closure mechanism now clarified, the search is under way for methods of raising the O_2 pressure of the blood in newborns or otherwise stimulating duct closure.

Heart Research Newsletter, 9:1, 1964

* * *

Roughly half (49.7 per cent) of the women in the labor force in Canada in 1963 were married; 40.2 per cent were single; 10.1 per cent were widowed, separated or divorced.

Dominion Bureau of Statistics

* * *

Youth is the time for looking ahead; age for the looking back; middle age is the period in which you merely look startled.

Personally Speaking

MURIEL UPRICHARD, PH.D.

This address was presented at the RNAO annual meeting on May 1, 1964

I have been asked, as a non-nurse, to "take a calm look at nursing," to say which way the profession is headed and to indicate the significance of this in today's society. In the first place, when I look at nursing I do not remain calm. This profession is essential to the health and welfare of the country. To see it in a state of indecision, dissatisfaction and disunion is disturbing; Canada needs a united and functioning group of nurses.

It seems only fair to tell you that, though I am not a nurse, I have some distinct biasses. The first of these is a belief that the function of hospitals is to care for and cure patients. All the other things that they do, such as medical research or training personnel, are subsidiary functions; they exist only because people become patients. The function of public health services is to provide a healthy environment; public health nurses exist to help people make optimum use of that environment. In other words, I am on the side of the patients, if sides must be taken. Most of you are too, although you may be a little confused as to how the best good can be achieved and a little bewildered about your own place in the achievement. My second bias is that I am on the side of the staff nurse in the hospital and in the public health field. These are the people who do the grass roots work of nursing. It seems to me that they are the people upon whom we impose the most.

You have discussed six areas concerning nursing amongst yourselves and the comments have been summarized for you by a panel. I propose to comment on these areas and then on the direction which I think nursing is taking.

What is nursing? It seems to me that an effort to define nursing is useful only as an exercise in the use of words. It is a good idea for nurses to get together and to think about this question, but many learned people have spent much time and effort trying to define nursing and none of the definitions completely pleases everyone. Though much of nursing is concrete, the spirit of it is abstract just as love, justice and truth are abstract. These abstract concepts cannot be caught in a net of words. There always remains something that is not quite said. Who tries to define the practice of medicine? of law? of teaching? It is useful to try; it stretches the mind, sharpens the use of words. I would not worry, however, if your discussion groups cannot quite get a definition that satisfies each one of you.

On the other hand, it might be very useful to define nursing in terms of function. All of you, or all who are prepared to do some concerted work, could do this. It might help to begin by saying what nurses are not. They are not, for example, maids, aides, telephone operators, receptionists, stenographers, messenger girls, plumbers, maintenance men, at one end of the scale, nor at the other end, are they pharmacists, anesthetists or obstetricians. What *are* they? Listing the functions of the nurse under ordinary day-to-day conditions could be very helpful. Then you would need a supplementary list of what nurses might do under emergency conditions — not the permanent emergencies that exist in some of our hospitals — but a real emergency of natural or man-made disaster. This is not a task for provincial office paid staff nor for the execu-

Dr. Uprichard, a psychologist, is associate professor at the School of Nursing, University of Toronto, Toronto, Ont.

tive committee; it should be done by the nurses who do the nursing. Get your little local groups together. Ask yourselves what the functions of nurses are. You will be surprised how this clarifies the mind, enabling you to fulfil your proper function better and to see its relationship to the non-nursing functions which are thrust upon you.

Role relationships grow out of the definition of nursing. If you do not know what your own role is, you cannot distinguish what anyone else's may be. This word "role" is much used and much abused. Role is a pattern of behavior appropriate to a particular position in a social structure. We all assume many roles: mother, sister, aunt, teacher, student, and so on. We move from one role to the other quite unconsciously because these have been inculcated in early life with the mores of our particular social group. Our professional role we learn from our professional education. We enter a profession with a preconceived idea of what our role will be. Education warps us into the mores of the professional group. All education tends to be at least a decade, if not a generation, behind the times so that professional mores which are inculcated into the student are often outmoded before the student comes to the reality of the working situation. Nursing education, being largely given within a rigidly hierarchical and traditional institution — the hospital — tends to inculcate mores that are out of keeping with the realities of the care of the sick in 1964. Perhaps I should add that the six per cent of nurses who are trained in the universities in Canada are also being inculcated with mores that may easily be out of touch with reality. Universities also are tradition-bound and hierarchical. They find it difficult to change their ideas.

It is not surprising then that there is a great deal of confusion concerning role relationship. Opinions range from "We must learn to do team nursing and to be the team leaders" at one extreme, to "Nurses should go back to the bedside" at the other extreme.

In the opinions compiled from the Survey, the person who was mentioned most often and most clearly in her relationship to the nurse was the registered nursing assistant. She was spoken of in terms of "usurping the nurse's real function — the personal bedside care of the patient." The change from the title Certified Nursing Assistant to Registered Nursing Assistant was mentioned over and over again as was the color of her dress, her shoes and her stockings. The implication was that the registered nursing assistant was attempting to supplant the registered nurse with the patient and to confuse the public about her position in the hospital. Compared with this, there was little comment about the nurse's relationship to doctors, pharmacists, other therapists and social workers, all of whom are, or should be, her peers in the patient-care team. It seems to me that the registered nurse is engaged in a negative struggle to maintain her own integrity by keeping the registered nursing assistant group down, rather than in a positive struggle to lift herself up into her proper peer group — which is, or should be, the doctors, social workers and other therapists.

The reason for this is that the mores inculcated in the schools of nursing is that the role of the nurse is to nurse the patient — that is, to give the actual bedside care: bathing, making the bed, feeding, giving medicines and treatments. When the nurse arrives on the wards of many hospitals she finds that the real situation is quite different. It is the registered nursing assistant who bathes and feeds the patients, makes beds, even gives certain medicines and treatments. There is something about the laying on of hands that makes some patients confide in some nurses. The registered nurse finds herself resenting, not so much the loss of tasks related to physical care, as the confidence of the patient. The fact is that many new tasks have opened up for the registered nurse but since she is not prepared for these, she tends to fight against change and wants to keep the tasks with which she is familiar.

The working conditions of nurses have been discussed at some length. I find myself in great sympathy with the nurses on this point. Although salaries are usually cited first as a cause of dissatisfaction, I am not sure that they

are the most important. I will start with them and pass on to what I think is more important afterward.

The staff nurse appears to feel that she should be paid more; that she should be given more consideration for previous experience if she moves from one hospital to another; that she should receive more for additional preparation. I agree with this — up to a point. However, I think that your real problem is not at this level. It is at the top levels in nursing. Take, for example, the onerous and arduous task of the director of nursing service in even a fair-sized hospital — perhaps 300 beds. If that level of responsibility were borne, day and night, 365 days a year by a business manager in a Canadian industry, what salary would he command? Think of the number of patients in the beds; the number of babies in the bassinettes; the number of staff — perhaps 150 staff, head and supervisory nurses, a director of nursing education, a flock of students, maybe 50 nursing assistants and 50 nursing aides; the liaison with the doctors and the other therapists; the responsibility for the equipment and the supplies. In this province, $12,000 to $15,000 would be a modest guess. What director of nursing is paid this sum? A larger hospital is all the more complex.

If the top salaries were commensurate with the posts, the number of increments could be greater at each level of activity, including the level of the staff nurse.

Now, of course, you may say that many directors of nursing are not worth that much money. This may be so, but the *job* is worth that much. The salary level should be decided in principle and then the people required and helped to level up to their jobs. This is the way the teaching profession got itself out of its trough some years ago. Get the salaries up; give a relatively short cut-off time for people to gain the qualifications; make the educational facilities available to enable them to do this. Thus you are using both a carrot and a stick. It seems to me that nursing, at the present time, has neither a carrot nor a stick.

I have no hesitation in going out on a limb and saying that I think there should be shift differential. All American hospitals recognize this principle. Our own federal nursing service has recently adopted the policy. The evening shift is very hard to staff; is often most inadequately staffed with nurses and auxiliary personnel; is undeniably the least desirable shift from the social point of view. Having said this I must again point out the other side. The hardest thing to do in nursing is to nurse on all three shifts in the traditional way. But this has many advantages for the patient and for the hospital. In my opinion, those nurses who are willing to nurse around the shifts should be paid the highest salary of their category; the evening shift next and the night shift next. I must add another rider to this. Differentials should be available to permanent staff and not to drifters. This is one of the ways in which nurses are very unprofessional. They expect to drop in on a hospital, be given a job, stay a few weeks or months and then drift off somewhere else. A nurse is not much use on a hospital ward until she has been there for some weeks or even months. If she wants the advantages of choice of shift and shift differential she should be prepared to sign a contract for a year.

The nurse is sometimes looking for a place where she can nurse the patient as she would like to do and she keeps moving, searching for this ideal place. The fact is that this is the pot of gold at the end of the rainbow. Every place has its dissatisfactions and its disadvantages. What nurses need to do is to settle down somewhere, work out the causes of the chief disadvantages and try to correct them.

One of the widely expressed dissatisfactions is with the budgetary hours of nursing care permitted under the Ontario Hospital Services Commission regulations. Many nurses spoke of this as being 3.5 hours of nursing care per patient in each 24-hour day. In public health a similarly rigid figure of one nurse to 4,000 or even 5,000 of population is often cited. Both of these figures, if they are adhered to rigidly, are much too inflexible because patients and families are not items on an assembly line. However, the other side of this story is that these figures

are *not* always adhered to. The director of nursing can juggle the available personnel to whatever ward or floor needs them at any one time. I must say, however, that I've been on a good many floors where no amount of juggling could provide anything more than a minimum of patient care.

There are many things to be said about this matter of staffing. The director of nursing is, in a large measure, responsible. She should be able, with the help of her staff, to undertake studies that would indicate the amount of staff needed. These studies need to be more than time and motion studies. Work sampling reveals much as do relatively long periods of observation with anecdotal records. Few directors of nursing are able to do this in both senses of "able." They are not able because they do not perceive their role clearly enough to slough off the responsibilities that are not theirs. Even if they could find time, they are not *able* because they have not the techniques of research. This matter of hours of patient care is also tied in with budgeting. Some directors of nursing cannot budget and therefore must take the administrator's word for the nursing budget. Actually, the nursing budget should be built up from the head nurse level through the supervisory level to the director of nursing and then, in consultation with the hospital administrator, an informed director, with good verbal skills, may be able to get all or most of what she needs.

Few staff nurses are aware of the extent to which their directors of nursing *do* fight for their rights, for salaries and so on. The training of the director of nursing and the mores inculcated do not permit her to tell her staff about this aspect of her work. Being a director of nursing is a lonely, difficult job. Many directors feel dismayed and frustrated at the swift changes in hospital administration and service. They feel they have failed the staff and the patients. This feeling is all the more intense for being unspoken. It communicates itself to the supervisors, to the head nurses and down the line. Your director of nursing needs your support, your help, your concrete suggestions. The lines of communication are blocked by the hierarchical structure but this is just one of the things that needs to be worked at and cleared away. I know many directors of nursing and I know none who do not have the welfare of the patients and the staff at heart. What a director of nursing may lack is the tools with which to make her dreams of patient care and nurse utilization come true, or the verbal skills to express her needs adequately, so that she is understood and appreciated.

I agree with you that the working conditions are not what they should be; that the care of patients is often lacking. I do *not* agree, however, that this is caused by either apathy or ill-will on the part of the directors of nursing, the administrators or the consultants of the Ontario Hospital Services Commission. It is caused rather by the inadequacy of the preparation of the nursing leaders; their lack of technical and verbal skills; the rigid hierarchy of the hospital and the public health service.

I would like to consider continuing education and basic education together. There appears to be almost no dissenting voice in relation to continuing education. You all agree that there should be more inservice education; more refresher courses; more night schools; more summer schools; more scholarships and bursaries for university courses; more university courses; a more liberal attitude towards letting nurses leave their work to take these courses. These expressions of opinion are borne out by the facts. More students are entering basic university programs to study for the baccalaureate degree and registered nurse diploma combined. More hospital graduates are seeking entrance into university programs for the Bachelor of Nursing degree. More are pursuing master's and doctoral degrees.

A great many nurses, then, are acknowledging by their acts, even if they deny it verbally, that their basic hospital preparation has not fitted them for the work they are called upon to do after they graduate. They do not feel ready to give skilled care to the critically ill; to become a team leader, a teacher of nursing, a supervisor or an administrator. They are

certainly not ready to become public health nurses. The only anomaly here is that many of these people *say* that they want to nurse the patient at the bedside. Even the university schools are confused about this. They say that they are preparing the nurse for first level hospital or public health work. The evidence of what the competent graduate of both hospital schools and university schools is doing one or two years after graduation belies these words. In fact, your actions speak so loudly that I cannot hear what you say.

You are very divided in your attitudes to basic education. The variety of opinion ranges all the way from "the hospital schools are fine as they are and should be left alone," to "let us get the schools into the stream of general education and the hospital schools closed." There is disagreement about the academic prerequisite: Grade XI? Grade XII? Grade XIII? There are differences about the length of courses: two years? three years? If preparation is not to be in hospitals, where is it to be? In the universities? In the independent schools of nursing? In technical schools? In high schools?

This is a highly complex question. I am going to point out one thing and ask you a number of questions. First of all *much of the opposition to any change in education is due to fear.* The diploma nurse is afraid, on the one side, of the registered nursing assistant and on the other of the university graduate. But the registered nursing assistant and the university graduate are both afraid of the diploma nurse. This fear is quite unnecessary. There is so much to do in nursing that there is a place for everyone and there will be for a very long time. In fact, there must be a steadily increasing number of nurses. The whole nature and tenor of our present industrial and scientific revolution indicates that more people must be in the service industries: serving other people as doctors, nurses, teachers, social workers, and so on. These fears cannot be resolved by my saying to you: "Do not be afraid; your job is quite secure." You would not believe me. Nor can the fears be relieved by your drawing back into protective shells. They will be resolved by open discussion of patient needs and of ways to use the abilities of the various categories of nursing personnel to the best possible advantage. There is a lack of people trained in leadership techniques. The resolution of these fears awaits the production of a head nurse-supervisory-administrative group of nurses who are well versed in the skills of dynamic group and interpersonal relationships.

Now for my questions. We have had hospital schools of nursing in Ontario for just 100 years this year. If, as many of you believe or profess to believe, these hospital schools are capable of producing the numbers and the quality of bedside nurses needed for the basic care of the patients and the highly technical assistance to the doctors, as well as the leaders needed as head nurses, supervisors, and administrators — where are they? Why is it impossible to find prepared teachers? Why are all too many posts for head nurses, supervisors and directors of nursing filled by seniority rather than by excellence? Why was it necessary to start courses for nursing assistants? Why are more and more of you pressing into the universities and urging them to expand both the numbers that they will accommodate and the kind and the extent of their offerings? Why are all the good schools of nursing trying to attract more and better teachers and expanding the theoretical content of their curriculum? I leave you to ponder these questions.

It is most interesting to note that though the Registered Nurses Association of Ontario was not originally a part of the province-wide study, so many comments were made that a special section had to be set up to deal with it. As your president said to you in a circular letter sent a few weeks back "There is no smoke without some fire." I have been working directly in the field of nursing for nine years and I have been aware during all of this time of a small but growing fire and an increasing amount of smoke. The emergence of the Committee for the Advancement of Professional Nurses as an organized group indicates that the fire has reached considerable proportions. There has been, and there is, a mounting dissatisfaction with the

quality of leadership given by the Registered Nurses' Association of Ontario. Since it is the function of a professional organization to uphold the standards of the profession, you obviously have some room for dissatisfaction.

But, turning that coin over, what is the RNAO? Do you think that some 30 or more paid employees working at 33 Price Street are the RNAO? They are not. They are the *servants* of the RNAO; they work under *your* direction and within the framework that *you* set for them. If you do not like what they do, you have the privilege of dismissing them.

Or, do you think that the officers of the association are the RNAO? Again, they are not. They are a group of people who have been elected within a constitution which was approved at some previous date. If you do not like the officers, don't vote for them! If you do not like the constitution, change it! It is yours. Every growing organization outgrows its constitution and has to create a new one from time to time.

I have been greatly surprised to discover that many of you confuse the officers with the paid staff. The officers give of their time voluntarily. It is extremely difficult to find people who will stand for office; many officers are elected by acclamation. This is not necessarily the acclamation of approval but the acclamation of default. Nobody else would run!

Many of the officers who have held a post for years and years do so because no one else will take it over. You complain that the officers perpetuate themselves. There may be some among them who do so because some people do like power. But again, this is true in every large organization. But, *someone* must do the work. All of these people have full-time jobs and it is their own private time that is taken up with the work of the RNAO. If they give up the job, someone else must assume it or the work will go undone.

You say that the upper echelons of administrative and educational people run the Registered Nurses Association of Ontario. This is true to a great extent. Perhaps this is one of the biggest weaknesses of the Association. The other is that the paid staff has not enough freedom within the constitution to initiate and take creative action. Their time and attention are frittered away on short term and often non-productive projects. Many of them, too, are not qualified for leadership positions but hold them because they are the best people that could be found. However, a structure study is underway and no doubt many of these difficulties and others will be observed and overcome. Voluntary associations should be non-hierarchical in structure. The administrative structure should reflect this. This in turn would improve the communications.

I thoroughly agree that the Registered Nurses Association should be doing research but I would point out to you the great difficulty in finding nurses who are equipped for this. We are back to a point that was discussed earlier. *The education provided does not produce the people who are needed.*

Finally, I come to the vexed question of collective bargaining.

I would like to tell you a cautionary tale. Of course, I am all too well aware that what we learn from history is that we *don't learn* from history. Nevertheless, I tell you this tale in the hope that you will see the moral clearly and that it will be possible for you to use reason and not emotion in making your important decisions.

In 1888, the British Nurses' Association was formed under the leadership of Mrs. Bedford Fenwick with the express purpose of upgrading education through the use of nation-wide examination and registration. There were, however, forces at work against registration including Florence Nightingale, the British Hospital Association, and the rural doctors. As a result, a rival group to the BNA sprang up, first of all working through the British Hospital Association. By 1896, internal dissension had split the BNA (by now the Royal British Nurses' Association) so that it had swung completely round and was denouncing the policy of registration. Mrs. Fenwick lost her key position in the British Nurses' Association. She formed another group, the National Council of Nurses, to secure state registration. Registration was in the air

generally. The doctors had had it since 1858; the teachers gained it in 1899; the midwives secured it in 1902. By 1904, the National Council of Nurses was sufficiently strong that they were able to pressure the government into setting up a Select Committee to investigate the situation. The Select Committee found in favor of registration.

Each year, between 1905 and 1914, a bill for the registration of nurses was introduced into the British parliament. By skilfully playing off the two factions of nurses against one another, parliament avoided having to face the issue of bringing the registration bill to the floor.

The first World War broke out and nothing had been done. Under the stress of war the matter was momentarily dropped. Before the war was over a new nursing body, the College of Nursing (now the Royal College of Nursing) was formed. The quarrel between the College of Nursing and the Royal British Nurses' Association was joined again. Due to the good sense of the government of the day, the quarrel was negotiated in private and a compromise bill was presented and passed in 1919. So open and vicious had been the attacks of these various groups of nurses upon one another that the wound was not healed. The nurses remained divided into two camps with many splinter groups within each one.

As membership in the ICN was dependent upon *one* nursing association representing all of the nurses of the country, this quarrel of the British nurses bade fare to wreck the International Council of Nurses at one point in the 1920's. It was not, in fact, until World War II that the active quarrel was laid to rest. Only death has stilled the bitterness in the hearts of many of these British nurses. Even now membership in the International Council of Nurses is through the National Council of Trained Nurses which combines into a nominal union some 62 nurses' associations.

I need not point out the moral to you. All human institutions go through stages and phases of development. These are rather like the waves and troughs of the ocean. Gadflies have their uses. They sting the mule into action. Splinter groups often have their uses because they sting the organization into action. They are harmful only when they go on stinging after the action has been initiated and thus split the organization. CAPN has played a very useful role this winter. Much of the success of the RNAO study is due to the fact that this group has pricked and stimulated thought and activity among nurses who realize the value of a professional organization and the value of unity and will strive to hold the group together.

If you want to introduce legislation about anything *you will gain your point only by being united*. As a matter of fact, this is the only strength that nursing has. The sympathy and admiration of the public is largely with the nurses. When you are seen to be divided and to be ready to undercut and undermine one another, you destroy your public image. In addition to this, as happened in Britain, if your group can be kept divided and the different parts played off against one another, nursing will be impotent and voiceless in the higher councils of the state.

Internal dissension troubles all human institutions. There is a difference in the way it is handled. Many of the older professional groups are wise and skilful enough to keep their quarrels strictly to themselves. There may be much heart-searching and there may be much incrimination but it is done behind closed doors and it is not divulged to reporters of newspapers.

Where is nursing going? I can only point out to you what is quite obvious to those who observe and ponder the state of our society.

The practice of medicine is becoming more complex all of the time. The field of knowledge has doubled in the last decade. There are more specializations and specialists. Means of diagnosis and of treatment are more and more complex. The doctor is with the patient less and less. You are his eyes and his ears; more and more you must be his *informed* eyes and ears. Being informed means that you must be in on the treatment plan of each patient. This demands revolution in the care-cure team. Doctors must become team leaders instead of dictators to the group. This will be as difficult for doctors as it will be for nurses. So this is the first role I see you stepping into — the role of the nurse con-

sultant in cases of critical illness.

You must become more responsible for the psychological aspects of the patient's illness. You regret the loss of the personal care of the patient because you feel that you have lost his confidence. I say to you that this is a very haphazard way to gain the patient's confidence — to hope that physical intimacy will produce it. Many patients are too embarrassed or too uncomfortable to prolong the bed bath or other such procedures in order to tell you their troubles. A planned, scientific approach and time to pursue it in relaxed face-to-face conversation could accomplish much more, particularly if nurses knew how to do this.

The hospital nurse must become more like the public health nurse in her teaching function. It is extremely important that patients should not go home from hospital unaware of their condition or how to take care of it and how to improve their health. We cannot afford to have continual reentries into hospital because the patient has not been taught.

There is an unexplored field of psychiatric nursing for which we have as yet only a handful of prepared people. The revolution in psychiatric treatment has created a new, large area that needs skilled nursing action. What are you doing about this? Nature abhors a vacuum; this virtual absence of the skilled psychiatric nurse cannot go on forever. If the nurses themselves do not move to fill the vacuum, somebody else must.

Public health nursing is changing in character. It must become *community* nursing working hand-in-hand with the hospital and other health and welfare agencies to care for people in their homes according to present need and not according to some preconceived idea. Ways and means of liaison with the out-patient department of both general and psychiatric hospitals must be found and the care of discharged patients must be undertaken.

Then there is the whole problem, which I have touched upon very lightly, of the need for major development in the concepts of supervision and administration. These two things must be separated and expanded. The supervisor should be supervising patient care. She is the person who should become the consultant to the head nurses and general staff nurses in cases of doubt or difficulty. Hopefully, the nursing consultant-supervisor will gain such stature as to be freed from the shift system and work on a truly professional level in response to patient needs.

Canadian women owe a great deal to the nursing profession. Your profession has contributed not only to making hospitals a place of refuge and rest but to raising the status of women. More than any other group, the war effort of Canadian nurses gained women the vote. Your past is glorious and you have nothing now to fear. Guide you ship by the star of better patient care. Your present difficulties will disappear in a concerted effort to achieve the true goal of the nursing profession.

Coming!

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AUGUST 1964

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Problems Affecting the Nurse's Status

OSWALD HALL, PH.D.

This article outlines the main features of the field of nursing, some changes going on within it, and the consequences of these changes for nursing and for those who train nurses — all as they appear to a sociologist.

The changes in nursing have been extremely rapid and almost incredibly substantial. The developments even in one lifetime have been tremendously extensive. Our generation has seen a fabulous growth in medical knowledge and medical care. When I was born there were almost no specialties in medicine. Today, there are over 30 well-recognized specialties, many of which are themselves tending to split into new specialties. Some of this specialization is mirrored in our hospitals which have become creatures of departments. Each department is, in some sense, a new and strange world to the others. In the course of a generation hospitals have changed character fantastically because of these developments. They have become specialized among themselves so that one hospital may carry on only a fragment of medical care. In brief, one can say that medical science and medical care have changed, individual hospitals have changed, and the whole species of hospitals has become more elaborate. What have these changes done to nursing?

Hospitals have become the main locus of the work of the nurse. It is *in hospitals* that they carry out their duties; it is the hospitals that pay their salaries. In a real sense this is news because this represents a radical change for the nurse. At the beginning of the century, on this continent, the *majority* of nurses worked individually in private homes. Today, it is estimated that only *one nurse in seven* works in such a private capacity. Over the course of a generation nurses have flooded out of one kind of nursing employment into a dramatically different form. This basic feature of the nurse's life has been revolutionized.

The move into the hospital setting involves an incredibly more complex set of work arrangements for the nurse because hospitals require such a large range of other kinds of specialized workers. There was a time when nursing brought the nurse into contact only with the patient and occasionally with the doctor. Hers was then a simple social world. The modern hospital involves her with an army of other kinds of personnel. In a big hospital the nurse is one among some 200 specialized kinds of workers. Her daily work touches on the work of almost all of these to a greater or lesser degree. This is one of the great consequences of moving from private practice into the hospital scene. For better or worse, the nurse is one cog in a vast complex organization.

The hospital has affected the nurse in another fashion. Like the doctor she has become a *specialist*. The various departments of the hospital force this development upon her, as does the emergence of specialized hospitals themselves. In the course of a few decades this development has tended to strain the label "nurse" almost to breaking point. Nursing is reaching the point where it designates a whole family of occupations rather than a single occupation. Some nurses not only work in independence of other nurses but may have their training separate from others. In some situations the psychiatric nurse has only a

Dr. Hall is professor of sociology, University of Toronto. This address was delivered at the annual convention of Catholic Schools of Nursing held in Montreal early this year.

remote acquaintance with other types of nurses. The hospital has split nursing into a set of distinctly different sub-specialties.

If we explore this situation a little further we will note that the hospital *deforms* nursing in various directions. The nurses on a hospital staff eventually come under supervision and direction. A schism develops in nursing — some become directors and supervisors, while others remain general duty nurses, people who carry on the traditional duties. Some do the work, while others give orders to them, supervise their efforts, and inspect the results. This could be looked on as a new kind of specialization in nursing, a kind of specialization that puts a strain on the relationships of nurses with other nurses; one which adds another complication to the teaching of nurses.

While all this has gone on, nursing has tended to split along still another line. Some nurses look after patients; some look after the equipment that is needed to treat patients. Here again what we see is a revolutionary shift. Once upon a time hospitals were vast wards of beds for patients while the equipment required little space. Now this is reversed. Only a fraction of the space of a modern hospital is accounted for by bedrooms for patients. Two-thirds of the space is used to house equipment and to provide for the people whose task it is to service these vast aggregations of specialized machines.

Although some of this machinery requires new types of technicians — people who have no training as nurses — some nurses tend to be highly oriented in the direction of technical equipment. Indeed, they may come to lavish more "tender loving care" on their precious machinery and equipment than they do on the patients; they may come to enjoy the association with equipment technicians more than with fellow nurses. Again, I emphasize that the changes in the hospital have exerted stresses and strains on nurses such that new kinds of nurses are required.

One of the ways in which nurses have come to deal with the new style of life which the hospital affords is to cast off some of their ancient tasks to new kinds of workers. In recent years nurses aides, practical nurses, and various other kinds of assistants have blossomed forth. On the surface, this looks like a highly beneficial arrangement, one which reduces the work of the nurse to some degree, and which allows her to concentrate on the more *complex* tasks of nursing, while relegating other tasks to people with less skill and less training. The arrangement, however, has had various unanticipated consequences, not all of which have been pleasant. Uncertainty has grown up regarding *what is* nurse's work and what belongs to nurses' aides. Touchy problems of prestige have risen. In some cases, the nurses' aides look less like useful helpers and more like aggressive competitors. They complicate life for the nurse as well as ease it.

Before concluding this statement about the impact of the hospital on the nurse, two more points should be indicated. First, the modern hospital has grown so large and complex that it seems to require a new kind of administrator. Administration has become a complex art now learned in a special course, not in nursing. The people who try their hands at hospital administration are not nurses so much as people selected from other fields. Bit by bit the chief administrators of hospitals are strangers to nursing rather than nurses as such. They tend to become a bit estranged from nursing, or are too busy to give it much attention.

The last point to be made here is that hospitals have become too complicated to be financed easily at the local level. More and more they have become part of larger hospital systems financed by provincial and federal revenues. Inevitably, their control moves into the hands of people who are neither doctors nor nurses. The real control of the hospital moves far outside the powers of nurses or nurses' associations, leaving the nurse as a mere employee of a large corporation.

How do these matters influence and complicate the teaching and training of nurses? Are there new facets to nursing training which had no existence a generation ago? What are the basic concerns, and worries, and problems,

of the nurse who goes forth from today's place of training? How are nurses trying to deal with their problems, and what help are their teachers giving them in these situations?

What kind of creature is today's nurse? She works in a hospital, one in which medical care is becoming increasingly specialized. She shares the spotlight with an army of new kinds of specialized occupations. She herself is more and more a specialist within her own occupation. She works in a bureaucratized setting, one populated by supervisors, executives, filing clerks, all of whom form part of great impersonal work teams. She lives in a world of extremely complex equipment which tends to give a factory-like character to her work place. She shares her tasks with an array of people below her in the hospital, each neatly graded in terms of skill and training. At the top of the hospital there now presides a new kind of administrator who in turn is flanked by new kinds of persons — kinds recently borrowed from the business world. The hospital itself is swiftly losing its individual character and is becoming part of the general cluster of social service institutions.

The Emerging Status of Nurses

Earlier, I emphasized that nursing, like so much else of medical care, is tending to concentrate in the hospital. This is the way the doctors prefer to practise medicine. Moreover, neither families nor homes are equipped to care for the sick; families are very ready to send their ill ones to the hospital. Medical equipment is so large, so heavy, so costly, so complicated, that it can only be made use of in the large hospital setting. All of these — the technical equipment, the doctors, the sick persons and their families — conspire to make certain that the nurse will spend her working days working *in* a hospital and working *for* a hospital.

This change in the "where" of nursing is a fateful change. It means that there is gradually emerging *one* major way of practising nursing — *in the hospital setting*. The fact of this development may only slowly sink into the awareness of nurses. For a time they may feel that their training opens for them the doors to many kinds of work situations. Eventually and inexorably they will discover that not only do they work *in* a hospital but that they have become *employees* of the hospital.

This point requires some elaboration; it is in essence my major point. To take an employee status in the hospital means, in effect, that the nurse renounces her professional status. It is impossible to run a modern hospital without a large contingent of employees including nurses; it is well-nigh impossible for the nurse to be such an employee and at the same time have the rights and privileges of a professional.

May I clarify my contention that this is a fateful change for nurses by calling attention to the status of nurses in hospitals as it used to be. It would be close to the mark to say that heretofore nurses have had, not one but three statuses in the hospital. They have had one status vis-à-vis the doctors, another vis-à-vis the administrators and other hospital staff, and a third status vis-à-vis the patients. These three statuses have often been contradictory and inconsistent, which has complicated life for the nurse. I shall say a little about each of them; taking a separate look at each helps to clarify the current position of the nurse.

The nurse's relation to the doctor in the hospital — her status — has been peculiar. She is not an employee of the doctor, nor is she his colleague. Yet she has in large part *acted as if she were both*. She takes orders from the doctor and obeys his orders implicitly. It is an open question as to whether she has feared him more or less than she has her own immediate supervisor. It is an open question as to whether her primary loyalty has been given to the doctor or to her supervisor.

The nurse in the hospital stands in a very different relation to the doctor from that displayed by a nurse in a doctor's office. But the differences as far as obedience and loyalty are concerned are treacherously difficult to specify.

By the same token the degree of

responsibility granted to the nurse in the hospital by the doctor is an uncertain feature of her status. Since the doctor cannot be in the hospital at all times (and indeed cannot be located anywhere part of the time) it is left to the nurse to take on responsibilities that lie on an uneasy margin between nursing and doctoring. So much is this the case that the hospital nurse can perhaps be better viewed as the doctor's right-hand man, the captain's lieutenant, so to speak.

This is a very murky sort of status — to be an employee but not an employee, to be a colleague but not a colleague. Either way one looks at this, it is clear that the nurse has had a substantial gift of status from the doctor. Even when related to him as employee she has borrowed part of his status (just as secretaries take over some part of the prestige granted to their important bosses). By the same token, her identification with the doctor as colleague, presiding like him over the drama of illness, has added to her borrowed level of prestige, as seen in the past.

If we turn our attention away from the doctor to the status of the nurse, vis-à-vis the patient, two matters stand out sharply. One has been the tendency in the past for the nurse to be assigned "patients" to care for, rather than duties on a ward. There is a vast difference between these two ways of viewing one's work. The nurse can either see herself responsible for keeping the ward going — in which case specific patients and their care are secondary; or she can view herself as caring for specific patients for the duration of their stay, in which case the ward becomes secondary; indeed, it becomes mainly the necessary environment within which she carries on her nursing responsibilities. As the nurse becomes more and more a hospital employee, her "patient-orientation" takes second place to her "ward-orientation."

These differences in orientation sink deep into the nature of nursing tasks. Let us consider for a moment how a nurse measures her time at her work. An employee tends to be a clock watcher, she tends to view the longer spans of time in terms such as shifts, pay periods or time between holidays. For the employee, time is given rather grudgingly in exchange for income. On the other hand, for the professional nurse, the one who is "patient-oriented" time is measured otherwise. It is patterned in terms of *the patients' time;* the time points become things like the following — the coming of the patient under her care, the passing of crises, the stages toward recuperation, the dramatic finale of discharge of the patient. Time measured by the relation to a patient is strikingly different from institutional time, which is measured impersonally.

While these comments about the relation of nurse to patient are presumably old stuff, a shift in the balance of these items, a shift which leads the nurse to see herself and think of herself as an employee rather than a professional, is a crucially significant one. This shift seems to go on relentlessly as hospitals grow larger and thereby require larger nursing staffs. Such staffs tend to become depersonalized. Moreover, they are allocated to their tasks in terms of the requirements of the institution and the economical provision of services, rather than in terms of a personalized relation between a nurse and a set of patients whom she knows, who come to expect her and look forward to her services. In this situation it becomes progressively difficult for the nurse to provide traditional bedside nursing. Instead, she provides what care she can for patients who are essentially strangers to her. In such circumstances she is prone to feel some guilt for not living up to the standards of care she was taught to idealize in nursing school. However, a vivid sense of guilt cannot change the impersonal relations back to the sort she was taught when she was in the training situation.

To sum up my comments about the status of the nurse — first, the blend of items which make up her status have been shifting, relentlessly and perceptibly. Second, her identification with the doctor has declined; she no longer shares so bountifully in the aura of his high prestige. Third, she can no longer identify herself with the drama of illness and recovery to the same degree as previously; her

concern for the specific patient recedes from the centre of her interests. Fourth, her identification of herself as an employee, hired by the hospital, has become more pronounced. These matters are all intertwined. The more she feels herself an employee the less she links herself to doctor and patient; but the less she does this the more she feels herself an employee. This process of alienation is therefore a bit of a vicious circle, or a downward spiral.

Let us now consider the *emerging* status of the nurse. What are her concerns insofar as she tends to adopt the status of a hospital employee? I view these from two points of view. First, what are the rewards for her work, and the conditions under which she carries on her work? Second, who has the power to control and change those things for her?

These things seem to be coming into clearer focus. Nurses are increasingly becoming concerned about their pay. They look at the incomes of people in comparable occupations and are disturbed by the contrast in size of pay envelopes. Moreover, they notice the greater speed with which improvements are coming to comparable occupational groups. They have learned that others are paid for overtime, and are paid more for overtime. They have heard of shift differentials and are asking why this does not apply to nursing. The length of the work day, of the work week, the number of paid holidays, are all taking on an increasing importance. Other items of concern are the "fringe benefits" — such things as meals, uniforms, pensions, insurance — all matters that have a very high importance in our employee-oriented society. It is true to say that nurses are becoming concerned about the conditions of work, and are no longer ready to give their services in an uncritical way.

One other concern of the nurses is worth noting. As employees, nurses work under supervision and inspection, *under foremen and inspectors* by whatever names these are called. Supervision can be of various kinds; it can be kindly and helpful, or it can be militaristic and irritating. Nurses, like employees everywhere, become sensitized to the quality of supervision. There is a natural tendency for supervisors to be looked on as virtual enemies. This can happen in nursing, even though the supervisor is a genuine nurse in her own right.

These concerns of the nurse, looked at together, seem oddly familiar. They are the very things that one hears about in the general work world. These are the responses that employees make in large work organizations wherever we study them. As a sociologist I would be prepared to say that hospitals are coming to resemble other large scale work organizations, and nurses are responding like the employees of other organizations. Or put it the other way, that which is unique about hospitals and nurses is shrinking in significance.

Who has the power to influence these matters, these concerns of the nurse? Do nurses remain a "free and independent profession" able to determine these matters for themselves; or has the power over these matters slipped, bit by bit, into the hands of people who themselves are not nurses? How do nurses view these matters? I shall argue that nurses tend to see the source of power at one or another of three levels.

For some nurses the source of power is located at the immediate work level — power and authority are viewed as being invested in their supervisors. In trying to understand her own situation such a nurse looks no further afield. Other nurses, however, look on the supervisor as being essentially an intermediary. They see her as someone who merely carries out orders and policies laid down by a higher authority. For these, the real source of power is the administration — a vague, shadowy entity that she may never have met face-to-face. The third view of power is that it lies at a still higher level, that there is an arm of government or a specialized commission that is the final source of power.

The way in which nurses respond to their problems depends a good deal on how they view the locus of power. If they think that the immediate supervisor is really in control of their lives, then they can hope that the matter lies in the control of the profession. If the supervisor is a nurse like herself — if

she has travelled the same paths and undergone the same experiences as has the employed nurse — then it is possible to hope that as nurses they can work these matters out together.

If, however, the nurse feels that the real power lies elsewhere, if she thinks that power is really wielded by a paid administrator who has never had experience in nursing — an administrator who hires both nurses and supervisors — then she may feel that her problem lies outside the hands of nurses. In such a case her alternatives are: (a) to carry with her a sense of helplessness, or (b) to form a union, as other employees are likely to do.

If, on the other hand, the nurse feels that the hospital administration is not all-powerful, that it is dependent on a department of government, or a government commission, then the response is likely to be different again. The union and the strike scarcely apply in such circumstances. The appropriate response is some sort of occupational association that can make its weight felt in a political way — through the voice of an association which speaks clearly and forthrightly for the people concerned.

This seems to be the present situation of nurses. They are perplexed by being pulled in these various directions, and tend to split into factions which try to choose one direction rather than another. The choice of directions is not strictly a practical concern; it has deep moral overtones. Some nurses feel that their problems should be worked out in the privacy of their profession; they feel embarrassed to have their concerns voiced publicly. Some are ready to embark on union organization, collective bargaining, and strike action; to others this is deeply repugnant. Some feel that they should be represented in the day-to-day politics that swirl around them; others feel that political activity would contaminate their work. On all these matters there is both a practical side and an ethical side.

These matters come to a head when nurses becomes organized in their own associations. Nurses' associations, like those of other highly specialized occupations, can turn in one of three major directions. They can concentrate on their own technical problems and become concerned about matters of new skills and new knowledge. They can take on the form of union organizations and battle for improvements in their status. They can take the shape of formal associations which employ spokesmen to influence the political world round about them.

The most *practical* choice for nurses might be some form of union organization which could bargain collectively. In the eyes of most nurses this is probably a disreputable form of association, one to be rejected. The *attractive* model is probably that of the medical association, which is both a scientific and political form. Whether it can solve the nurses' problems remains to be seen.

The Politics of Nursing

In emphasizing this thought that nurses are becoming employee-oriented, I am not arguing that nurses realize this clearly or that they have no comparable problems on their doorsteps. Like other occupations in our society they face a nest of problems, many only dimly perceived. They face the question of recruitment. At times they wonder if they are recruiting their fair share of the kinds of people they want — with the proper educational background, of the right age to be trained, of the proper racial, language and religious backgrounds, of the proper attitude toward nursing, and so on. They worry about the new paramedical people who are doing some jobs once done by nurses; and they worry about their own abilities to keep up with changes in medicine and nursing. Most of these problems are connected to some degree with the one I have emphasized — the transition to the status of employee and the efforts of nurses to organize to deal with their problems.

Let us now look at the *strategy* to be employed by nurses' associations. Once such associations start the struggle to control their own destinies and fates they immediately look around to discover who are their enemies and who are their friends. Whom should they attack? Whom should they seek as allies?

It is usual in our society for employees to attack their employers — to view them as natural enemies. In some cases this is not easy. The employer may be so powerful that it is positively dangerous to attack him, to threaten to go on strike against him. In other cases he may be so deeply loved and/or respected that it is equally difficult for employees to organize for attack. When we ask this question about nursing, the answer seems clear — their employers, the hospitals, are *poor* employers. They are poor in both senses of the term—they haven't much money, and they haven't been much concerned about the welfare of their employees. This is far from surprising. Hospitals are not set up to make money out of illness — if they are helping the ill they will always be short of cash. And if they are seriously concerned about the patients, they obviously can't go very far in making life ideal for their staff. Obviously, the staff is there to *serve* the patients, even if it demands both sacrifices and immense effort on the part of the staff. Having noted all of this, nurses look at their contemporaries in other occupations who seem much better treated and ask "why us?" Even if the relationship between nursing associations and hospital administrators do not deteriorate it seems safe to assume that these two groups are hardly likely to become warm allies.

One direction in which the nursing associations might turn would be to the medical associations. In the past the doctors have helped the nurses with their problems of organization. In Ontario they helped to create the Association of Registered Nurses. More recently this cooperation has diminished. Each association has gone its own way. When medical affairs have been scrutinized by a Royal Commission, the two kinds of associations seem to have found no grounds on which they have tried to act together. Neither seems to offer help to, or seek it from the other.

So, too, there seems to be little common ground between the nurses and the new paramedical workers such as the nurses' aides. That situation is a bit like doctors and nurses. Nurses help the aides to organize but the result is separate organizations rather than a common front.

Where, then, can the nurses' associations turn for allies? The most obvious place, outside their own ranks, is to the staffs of the nursing schools. Many of the staff of such schools are nurses though, of course, they are also teachers. Indeed, they may be *teachers first* and *nurses second*. If so, their graduates may remember them as the stern disciplinarians of the classroom, rather than as well-beloved fellow nurses.

On balance it would be safe to say that nurses in general look to their one-time teachers for leadership in matters concerning their associations. They give them positions of leadership in the associations, and turn to them for advice and guidance. They tend to see the teaching staff as composed of superior sorts of people. They are thought to be more literate and more articulate; more sophisticated and better acquainted with the larger world round about; hence, the desirable spokesmen for the nursing association, for the nurses when they face new problems. Because they tend to view them in this favorable light, they feel a sense of alienation and annoyance when the teaching staff fails to champion their causes.

Although nurses would like to have their one-time teachers as allies and spokesmen, there are some awkward difficulties which stand in the way. Indeed, the better the teachers are in their work, the more difficult it is for them to be the kind of spokesmen the rank and file of nurses wish. Perhaps it can be put this way. The better the teaching staff, the more likely it is to keep raising the standards of the school. But when a teaching staff does this it tends to make its earlier graduates out of date. The more the teaching staff does to foster new advances in nursing — the more it strives to improve training — just that far does it make the older graduates feel obsolete. Indeed, the advances of the teaching staffs tend to make life harder for graduates. The better the current teaching the worse the older one looks.

There is a bit of an anomaly here, and grounds for misunderstanding. If

the practising nurses become subject to public criticism they often look to their one-time teachers to come to their defence. Often it happens that it is just those one-time teachers who are criticizing the older nurses for not keeping up with advances in nursing. This is a hazard that arises often and everywhere between teachers and their alumnae, but it is peculiarly painful when those who feel obsolete also feel deserted by those who once taught them.

It is scarcely possible for teachers of nursing to escape this situation and the roads open to them are not easy ones to follow. They cannot avoid the fact that nurses turn to them for help. Will nurses continue to do this? Will they continue to hope that the nursing teaching staffs will be their allies, their understanding allies? Will they continue to look to the teaching staffs to give leadership in the associations and act as spokesmen for the working nurses, helping those nurses to formulate new goals and to work toward them? Will the teaching staffs maintain an air of neutrality, of impartiality, aloof from the political squabbles in which nurses now find themselves? Will senior nursing staff members be viewed as thoughtless renegades, who dissociate themselves from the working nurses when the latter need help, and who join the academic, "ivory tower" teachers instead?

The relations of teaching nurses and student nurses have rarely been ideal. Wherever the student nurse has given service to the teaching hospital there has been a conflict of interests. The teachers have been *part* teacher and *part* supervisor, while the young nurse was *part* student and *part* worker. There are signs that these strains are easing. But while they have eased, new problems have sprung into existence. The new status of hospital employee, into which the graduating nurse will step, has raised a set of questions about the relations of teachers and their alumnae which cannot be bypassed.

This article began by focussing attention on the nurse; it ends by focussing attention on the nurse and her teacher. Whatever is happening to change the character of nursing is of deep concern to the teachers of nurses. I have tried to set out some of the sociologist's views of the matters. I have noted the changing character of the work place in which nursing is done; the vast range of associated occupations that have arisen; the specialization that has emerged among nurses themselves; the addition of auxiliary forces to the nursing component in the hospital; the formalization of authority and supervision in the hospital; the expanding technology of nursing; the increasing concern of nurses over their incomes and conditions of work; and their fumbling efforts to create a form of nurses' association which can tackle the new range of problems faced by nurses.

I have argued that the nurse is becoming essentially an employee of a large organization, and is starting to act and feel like an employee. You may agree, or you may not. You will probably, however, agree that the task of *training* a nurse for this new kind of medical world is not being simplified; and that the relations of teachers to their one-time students may be a bit more noisy, and a bit rougher, than they have been in the past.

Five broad occupational groups accounted for the majority of women workers in Canada in 1963: 30% in clerical work; 23% in personal services; 15% in professional services; 11% in manufacturing; 10% in commercial occupations. The balance was scattered among various occupational groups, e.g. agriculture and managerial.

— Dominion Bureau of Statistics

There are three kinds of people — rowboat people, sailboat people, and steamboat people. Rowboat people need to be pushed or shoved along. Sailboat people move when a favorable wind is blowing. Steamboat people move continuously, through calm or storm. They are usually masters of themselves, their surroundings, and their fate.

— Author Unknown

SUPPORTIVE THERAPY for the Surgical Patient

BARBARA JOHNSTON

Of the sum total of patients in a general hospital, most of them have medical diseases. If and when the medical conditions require surgical intervention these patients become surgical patients.

In the transition from medical to surgical status, each patient retains his basic needs as a medical patient: nutrition, fluids, elimination, correction of deficiencies, combating infection, and reassurance. He also develops the needs peculiar to a person about to undergo a surgical procedure which will make him feel ill before he will consciously realize its benefit.

There are four main types of surgery: curative, diagnostic, palliative and reconstructive. The operation can be elective or emergency. The type of surgery and the length of time that elapses between the recognition of the need for surgical intervention and the actual performance of the operation have a bearing on the patient's emotional reaction to surgery.

Many other factors also influence his reaction. The responses to the following questions indicate this. "Who is this patient?" The answer encompasses the major stones in the foundation of the patient's life: his sex, age, marital status, position in his family, cultural background, race, religion, occupation and the part he plays in his community; in general, his total role in society. "How will surgery affect the patient's role in society, especially in respect to his family and his mode of earning a living?" "How does he regard the surgery itself — as a curse, blessing or necessary occurrence?" Hospitalization is a new and often baffling experience. The patient is forced into a new role, one which is, in many cases, far more dependent than any of the roles that he assumes outside the hospital. Who will help him to accept his new role with a sense of security, assurance and trust?

More and more, total patient needs are being met by the entire health team composed of the doctor, nurse, nursing assistants, public health and visiting nurses. In this way the patient receives the benefit of a united attempt to rehabilitate him to the greatest potential for normal life that his condition will allow.

In the team system the doctor and nurse take chief responsibility for helping the patient to achieve a positive attitude toward surgery and his condition in general. Under the doctor's direction, the nurse is responsible for assembling the nursing care plan, keeping in mind the individuality of the patient and the over-all goal of his care. What must she evaluate when she is preparing to formulate her plan? First of all, she must relate the type of surgery to her patient by answering the previously mentioned question, "Who is the patient?" This question sums up all psychological care into one proclamation: The surgical patient is an individual and deserves to be treated as such. The team system meets this need because it makes him an integral part of its membership. He becomes a participant in his own care, not just a recipient possibly with a resentful, dependent attitude. The nurse who shows friendliness, understanding, empathy, reassurance, and sincere interest is

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Miss Johnston, a third year student at St. Boniface General Hospital when this study was written, was awarded first prize in the 1963 Macmillan Award Competition.

usually able to "get to know" her patient preoperatively, and is able to formulate a psychologically sound nursing care plan.

Since the nurse realizes the important influence attitudes and emotions have on her patient's reaction to surgery, and on his recovery from it, she must make a real attempt to discover what his reactions are. To do this, she should listen to him, encourage him to express his ideas. Observing him with others, especially with his family, will often give her an indication of his feelings.

It has been said that the usual reaction to surgery is fear. Fear of the unknown, of death, cancer, pain, anesthesia and mutilation is most common. Fear is heightened by misconceptions, unexplained procedures, and a lack or absence of confidence in the doctor and health team. The manifestations of fear are diverse; the most common are depression, anxiety and apathy.

The nurse's responsibility is to learn what the fears and their causes are, and then to rectify the causes if she can, or relay the information to the doctor. The patient should be treated as an individual. His modesty should be protected. Procedures should be explained in a manner that he can understand. The nurse should encourage his confidence in the health team by being a cooperative member herself. She should keep clear the channels of communication between the doctor and patient, since an anxious patient in a strange environment is apt to forget to ask important questions of the doctor, unless he is reminded by the nurse. Sometimes he cannot remember what the doctor has explained. The nurse, as she attempts to explain or teach, should first find out what the patient already knows and build on this, clarifying any details that may be troubling him. The nurse can also help to allay fear by giving hope (never false) and reassurance to the patient. Fear of pain can be alleviated by explaining that analgesics may be administered to counteract postoperative discomfort. The anesthesist's visit preoperatively helps to relax the patient and reduce anxiety concerning death during the operation; being awake when the incision is made; talking while recovering from anesthesia. Most important in overcoming fear is the intangible feeling of being "cared about" that a health team can give to the patient. This feeling should be carried over to the patient's family, who should be treated with respect, not as unwanted visitors.

The importance of preoperative teaching should never be underestimated. It helps to reduce fear of the unknown and consequently relieves depression, anxiety and apathy. It makes postoperative care much more effective since the patient understands why and how important procedures are carried out. It also helps to prepare him for going home. If the surgery is to be diagnostic, good preoperative teaching is reassuring since it indicates hopefulness on the nurse's part, and as a result the patient takes heart also. In reconstructive surgery, preoperative teaching helps the patient to understand that the results may not be just what he expects, and so helps him in rehabilitation. In emergency surgery, preoperative teaching is, by necessity, minimal but reassurance should be given to the family and patient. Thus, by reducing fear and by smoothing the postoperative period, preoperative teaching and all other preoperative psychological measures help make the patient a better surgical risk.

The spiritual needs of the patient should always be provided for. It is the nurse's responsibility to contact the patient's spiritual advisor if he so desires, and if his family is unable to do so.

The nursing care plan formulated in the preoperative period continues to give individual attention to the patient's postoperative needs. Attention is now directed to the prevention of complications, such as overdependence on the health team, thus hastening full recuperation. The same principles of teaching are used postoperatively but more emphasis is placed on how the patient will manage when he returns home and the problems he will have to face. This is especially important if his condition will warrant special care such as dressings, irrigations or injections. Information in regard to visiting nurse services could be given at this time. If the patient can be expected to

undertake his own care, he and a family member should be taught at the earliest opportunity how to meet his special needs. Doctor's orders regarding diet, exercises, irrigations, return trips should be discussed with him to ensure complete understanding. Gradually, the patient becomes a physically and mentally independent person.

In postoperative psychological care, the arts of listening and of sharing ideas are practised by the nurse. As can readily be seen, postoperative care is a continuation of preoperative care, with the same principles being utilized. Since good psychological care goes hand in hand with good physical care, the surgical patient who receives both will reach the goal set by the nurse and doctor more easily; rehabilitation to the greatest potential for normal, healthful living.

A CHILD WITH PHENYLKETONURIA

BERNICE SCHNEE

Early detection, prompt dietary control and strict supervision are essential in preventing the dreaded complication of this disease — mental retardation.

Phenylketonuria, (PKU) or phenylpyruvic oligophrenia, is a rare metabolic disease transmitted from parent to child through an *autosomal* recessive gene. Since it is caused by an *autosomal* gene, that is one not located on the sex chromosome, the condition occurs in males and females with equal frequency. It is present in approximately one out of 25,000 Caucasian births. Unless discovered and treated early in life, it leads to mental retardation.

These children lack an enzyme necessary for the conversion of the amino acid, *phenylalanine*, to tyrosine. When such a lack exists, phenylalanine begins to accumulate in the body fluids as soon as the baby begins to take milk. Part is excreted in the urine, but large portions are converted to phenylpyruvic acid by transamination. It is believed that the high concentration of these acids damage the central nervous system and result in brain damage.

Various signs and symptoms indicate the presence of PKU. The child may have a history of feeding difficulty in the early weeks of life with vomiting and colic; he may have changes in normal muscle tone, altered deep reflexes, mild tremors, or involuntary muscular movements; infantile spasms or convulsions may occur; an abnormal EEG may be found in the absence of seizures; as he grows older, behavioral changes such as aggression, destructiveness, and restlessness may occur.

Early detection of phenylketonuria is imperative if mental retardation is to be prevented. The onus for early diagnosis rests on the physician, the hospital clinic and public health department in the community. New cases of PKU are often discovered when investigating newborn infants who have relatives with the disease. Other cases are identified at a health centre where they have been taken to receive immunization injections.

Testing of urine for phenylpyruvic acid is the usual method of diagnosis. "Phenistix" dip sticks, strips of absorbent paper impregnated with ferric chloride are used. The prepared end is moistened with fresh urine and, if positive, will turn grey-green within one minute.

If the diagnosis is confirmed, the infant will be put on a diet low in phenylalanine. If started in the neo-

Miss Schnee was a senior student at the University of Alberta Hospital, Edmonton, Alberta, when she wrote this article. It received Honorable Mention in the 1963 Macmillan Award Competition.

natal period, this can bring the serum phenylalanine level to within normal limits and prevent development of mental retardation; dietary treatment commenced within two or three years after birth may arrest the brain damage.

*Lofenalac** is a balanced, low-phenylalanine food that is used as the main source of nourishment for children with phenylketonuria. It is made from a special casein hydrolysate low in phenylalanine combined with fat and carbohydrate. Vitamins and minerals are included to provide amounts similar to those in the usual milk formulas.

In Alberta, the government provides this dietetic preparation for infants and young children suffering from phenylketonuria, cost free up to the age of six years.

Philip Lane, aged 15 months, the third son in a family of three, was admitted to hospital with a diagnosis of phenylketonuria. This was his second admission and was to determine whether or not his previously prescribed Lofenalac diet was maintaining an adequate, but not excessive, phenylalanine intake.

Mrs. Lane, a nurse, told me that Philip had been a full-term, seven pound baby, who was delivered without difficulty. Because his brother was phenylketonuric, she had taken Philip to a well-baby clinic when he was three weeks old. His urine was tested with "Phenistix" and discovered to be positive for phenylketones. He was then admitted to hospital where further diagnostic tests revealed a serum phenylalanine level of approximately 18 mg. per cent (normal: 3-5 mg./100 ml.). A low phenylalanine formula of Lofenalac was prescribed and he was discharged to the care of his parents.

Philip had developed normally for a child of his age. At seven months, he sat up and began to drink from a cup; at 12 months he stood; at 13 months he walked with assistance and was able to finger-feed himself. He indicated wet diapers by pointing to them, but did not make an attempt to pull them off. Since he had not shown readiness for toilet training, his mother had not started to train him.

The Lanes seem to have a happy home life. Philip has two brothers, aged three and four years; the youngest was diagnosed at 18 months as having phenylketonuria. Philip was brought to hospital by his parents who have a good understanding of their son's condition. This second admission was not a trying experience for them. Philip played with his mother's fingers and the buttons on her dress; he was unconcerned by the activities of the nurses and doctors, probably because his mother was present throughout the admission procedure.

To assist the nursing staff in giving individualized care to Philip, I recorded on a "Personal Information Sheet," the information supplied by the Lanes concerning Philip's siblings, his eating habits, bowel and bladder independence, the words he used to indicate various activities, his play interests, and sleeping and personal hygiene habits. The physician completed the physical examination and history. Mrs. Lane then dressed Philip in a play suit while I recorded his temperature, weight, and admitting notes on the chart. After introducing the family to the charge nurse and to some of the staff, I showed them about the ward, indicating the playroom, bathroom, and visitor's waiting room. I explained ward routines, meal times, and visiting hours. I encouraged them to come at supper time, if possible, and stay so that they could be there at Philip's bedtime.

In the days that followed, Philip received daily baths; his temperature was taken rectally twice daily; he slept an hour or two each afternoon and 11-12 hours each night. The nursing staff watched for rash, cough, or nasal discharge; they noted the frequency, quality and quantity of urinary excretion and bowel movements; they charted his behavior in detail.

During his two-week hospitalization, investigations were carried out to ascertain the degree of control and adequacy of the diet. These included: chromatography of urine and blood, and quantitative estimation of serum phenylalanine levels. Routine investigation included a skeletal X-ray to detect osteoporosis; this was negative. Hemoglobin remained satisfactory at 12.3 Gm.%. He was rated as normal on a Yale Development Scale which tested his motor, adaptive, and language skills, as well as personality development. It was believed that the diet was inadequate since his appetite was not satisfied and he was underweight for his age. The physicians decided to increase his diet in calories and phenylalanine content while following him with blood and urine

* Mead Johnson and Company, Belleville, Ont.

investigation tests. The dietitian composed a diet that would be extremely low in phenylalanine. His serum phenylalanine level decreased from 20 mg. % to 10 mg. % during the first week and from 8 mg. % to negative during the second week of his hospitalization. A qualitative test for phenylpyruvic acid was negative. During the last week of hospitalization, the "Phenistix" dip test was also negative.

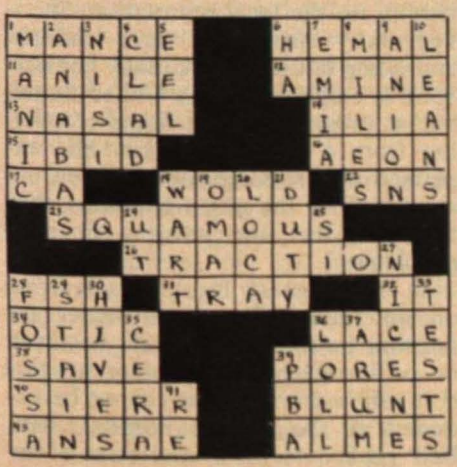
The dietitian interviewed Mrs. Lane periodically during the two week period and reviewed Philip's new diet with her. My request to attend these interviews was granted and I was able to cooperate as a liaison member in the team of the doctor, nurse, dietitian and mother. The formula ordered for Philip was 10 tbsp. of Lofenalac, 32 oz. of water, and one ounce of whole milk. His breakfast consisted of eight oz. of formula, two tbsp. of beets, and rice cereal with one tsp. of honey and water. His dinner included a vegetable, usually peas or beans, some fruit, generally pears or peaches, two tbsp. of rice cereal with honey and water, and eight oz. of formula. For supper he had a vegetable, fruit, and eight oz. of formula. At bedtime Philip received another eight oz. of formula. Between feedings, he could be given water and carbonated drinks. He preferred ginger ale, especially when the fizz had been removed by letting it settle. He also received Poly-vi-sol 0.6 cc. per day. We were able to increase dietary intake and yet maintain the required blood level of phenylalanine during this time. His appetite was thus satisfied and he gained weight while in hospital.

Each day, I checked his tray to see that only the prescribed foods were given to him. I closely observed the amount of food he consumed. All staff, including ward aides, housekeepers, and janitors, were informed of Philip's strict diet and cautioned against giving him foods that he should not have, such as fruit juices and cookies. In this way, mistakes were avoided and Philip's strict low phenylalanine diet was maintained.

Well aware of the importance of a definite dietary regime, Mrs. Lane was determined to follow it closely. She accepted his condition and planned to continue his diet therapy at home until the physician ordered otherwise (usually around 4-5 years of age). A follow-up appointment was made with the pediatrician.

While working with Philip and his parents, I learned much about phenylketonuria and the necessity of early diagnosis for effective treatment. I learned about the importance of dietary requirements, supervision and the nurse's role in such supervision. I also realized the value of nurses working closely with the doctor, other members of the health team and parents, and how such a team can function successfully for the benefit of the patient.

Solution to June Puzzle



The Office Nurse

A day or two after the doctor has made a house call, office nurse Mrs. Phyllis G. St. John of Sarasota, Fla., follows it up with a phone call. "Just to make sure things are all right," she says, "or in case there's a question or two." The calls are greatly appreciated, she finds, and may also save the doctor a night call.

Squibb *Nurses Notes*

* * *

A new toothpaste with food particles in it will soon be on the market; its for people who can't eat between brushing.

* * *

Cleave ever to the sunnier side of doubt.

LORD TENNYSON

Herniated Intervertebral Disk

LINDA DOWDEN

When conservative measures prove ineffective, surgical intervention is necessary. The eventual outcome is influenced by the quality of nursing care given before and after surgery.

Ever since I have been old enough to read, I have taken an avid interest in other cultures. As a child, I used to have many dreams: One day I would be in Switzerland climbing the Alps with Heidi and Peter; another day I would be in China meeting the king with Marco Polo. But I would always drift back to Canada and find myself with the native Eskimos and Indians. The Eskimos were far away and I did not get to know them, but the Indians were part of my native city. Beautiful books illustrated their long and colorful history, and classes at school brought them to life. Excursions to historic sites and museums were fascinating; for me there was nothing more interesting than gazing into a glass case and seeing small dolls with buckskin dresses and beady eyes staring back at me.

It has been a long time since I looked through picture books and longed to look in glass cases. Last week, when I walked into a room on the surgical unit and saw those same little dolls, a feeling of excitement and nostalgia enveloped me.

A pleasant looking, young Indian woman was sitting beside her bed, patiently sewing tiny garments to fit Indian dolls. Although she appeared to be very shy, there was a true warmth in her smile. When I showed an interest in the dolls, she seemed pleased and explained that this was her hobby as well as a source of income. Each doll was made with care and patience; every stitch was made as though it was the most important part of the doll.

It was not difficult for Mrs. Bell to create these dolls since she herself is a Six Nation's Indian. Although her mother was a Mohawk, she was born into the Onondagas since her father was a descendent of that tribe. At marriage, she accepted the customs and language of her husband's tribe, the Cayugas. Each year all the tribes meet for several days at the "Long House," their church, where they worship, pray to God, and give thanks for the past year. Although Christianity is their belief, they seek the grace of God through tribal dances. In colorful beaded costumes, the dancers weave in and out; each intricate pattern and movement has its own significance and meaning to those present. A vivid picture is imprinted on the viewer's mind; for Mrs. Bell, it is very important that she remember the costumes and masks so that her dolls may be true replicas.

Mrs. Bell lives with her family and parents on the local reservation. She is kept busy caring for three children and doing housework. Usually her husband is employed in the United States, but at present he is at home recovering from a fractured ankle. She explained that although he has been unemployed for the past six months, they have not had any pressing financial problems.

It is customary for a person living on an Indian Reserve to enter the hospital on the reserve if ill; however, he or she may enter another hospital if it offers services that cannot be obtained at the reserve hospital. Mrs. Bell applied to the Department of In-

Miss Dowden is a second year student at Brantford General Hospital School of Nursing. This article received Honorable Mention in the 1963 Macmillan Award Competition.

dian Affairs and received notification that her insurance would be valid in the outside hospital.

History of Illness

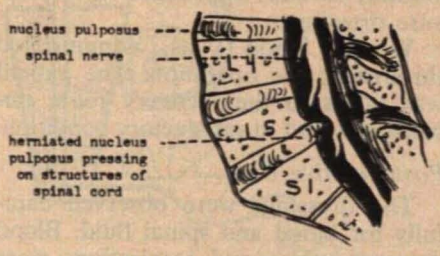
Three years following her second pregnancy, Mrs. Bell experienced pain in her lower back which at times became quite severe, radiating into the buttock and down one or both legs. The pain was intensified by straining, coughing, lifting, etc. At this time, the physician advised hospitalization for conservative treatment of a ruptured intervertebral disk in the lumbar region. The patient was placed in traction for two weeks and was discharged home feeling much more comfortable.

Soon, however, the pain returned. The patient became very discouraged since it was too severe to allow her to work and at times forced her to remain in bed. Since her husband came home only once a month from the U.S.A., she had to depend on the children for help. Tasks that require standing were the most difficult; the eldest children washed the dishes, dusted around the house, cut the grass and weeded the garden.

Around this time Mrs. Bell became pregnant with her third child. It was an easy nine months since she was free of back pain. She began to believe that whatever had caused the pain had somehow corrected itself. To her dismay the pain returned several weeks after the baby was born. Finally, she was referred to an orthopedist who recommended hospitalization for investigation.

A myelogram carried out in hospital revealed that the disk between the fifth lumbar and first sacral vertebrae had become dislodged and had moved laterally to the left, putting pressure on the first sacral nerve roots.

The physician drew a picture of the vertebrae and explained to the patient how the cartilaginous disks act as shock absorbers. He told her that the *nucleus pulposus,* the mass of semi-fluid material found in the centre of the disks, had herniated and was putting pressure on the nerves. This resulted in pain which had become more severe in the last few years. He pointed out that it had been nine years since she first experienced the pain, and during that time, conservative measures had proven ineffective. He advised surgery to remove the protruding disk. Mrs. Bell returned home and was re-admitted to hospital a month later for laminectomy with extirpation of the lumbar disk.



Herniation of Lumbar Intervertebral Disk

Present Admission

Preoperative Care

Mrs. Bell seemed at ease and almost unconcerned about the approaching surgery. She admitted that she had some fear but that the prospect of finding relief from the pain far outweighed these feelings. She realized, however, that the pain and discomfort would persist for a while postoperatively because of local edema. It was not difficult to orient her to her surroundings since she had recently been in hospital and knew most of the routines as well as the personnel on the surgical unit. She was very friendly toward the other patients in the four-bed room and seemed to enjoy the prospect of having their company.

Since Mrs. Bell's diagnosis had been established previously, the only necessary tests were the routine urinalysis and hemoglobin. The doctor also ordered bleeding and clotting times and a crossmatch for 2,000 cc. whole blood. Urinalysis was negative for sugar, acetone and albumen. Hemoglobin was 11.8 gm./100 ml. of blood.

A fracture board was placed on Mrs. Bell's bed to provide firm support. The evening before surgery, the nurse washed the lumbar and sacral regions of the patient's back with a surgical soap to make the skin as germ-free as possible. She then shaved the area. A hypnotic was given h.s. to ensure a good night's sleep.

Surgical Procedure

This consisted of: excision of the ligamentum flavum; widening of the interlaminar space by partial removal of the adjacent laminas; retraction of the dura and nerve root; incision of annulus fibrosis; excision of all of the nucleus pulposus; irrigation of the wound; closure; application of a pressure dressing.

Whole blood was administered throughout the operation. The patient was taken to the recovery room unconscious and in satisfactory condition.

Postoperative Care

The dressings were observed carefully for blood and spinal fluid. Blood pressure, pulse and respirations were checked frequently until the patient was conscious. Demerol 100 mg. was administered intramuscularly for pain in the operative area.

Prior to surgery, Mrs. Bell had been taught to "log-roll" when turning from side to side. For greater comfort and ease in turning, the patient's gown is removed.

With the bed flat, the patient places her arms at her sides and makes herself as stiff as a log; using a sheet which extends from the patient's shoulders to below the hips, the nurse gently turns the patient toward her.

The length of time spent in bed varies according to the surgeon's preference and the type of surgery performed. While the patient is on "complete bed rest" it is essential that she be turned in this "log-rolling" fashion — generally q.2-4 h. When using the bedpan, she should be helped to *roll* onto it rather than to *lift* herself on it.

Following this type of surgery, some patients experience bladder dysfunction. Mrs. Bell was unable to void the day of the operation; she was not catheterized, however, since her bladder was not distended. She voided 350 cc. the following morning.

The surgeon visited Mrs. Bell the day following her surgery. To her surprize, he raised her to a sitting position on the side of the bed. He then explained how she should raise herself from the bed so as to avoid straining her back. Following this, the patient complained of severe pain in the operative area and was given the analgesic ordered. She took little of her fluid diet that evening and again complained of pain that radiated to the buttocks and thighs.

On the second postoperative day Mrs. Bell showed great improvement. She did not require a narcotic injection during the day, was able to tolerate a light diet, turned well and, generally, felt more comfortable.

On the third postoperative day, she sat up in a chair for 15 minutes in the morning and afternoon. Each time she was glad to return to bed but realized the value of this activity. On the fifth postoperative day, she walked about her room with the help of two nurses. She was slow, but did not complain of any discomfort. She seemed pleased with her progress. Each day a physiotherapist visited and helped her to do exercises to relieve muscle spasm in the back and thighs. Ten days following surgery, the doctor removed the sutures and applied a light elastoplast dressing.

Mrs. Bell remained in hospital for 12 days. Before she went home she was allowed to have a tub bath. Here, again, it was essential to stress the importance of body alignment while bending and moving about.

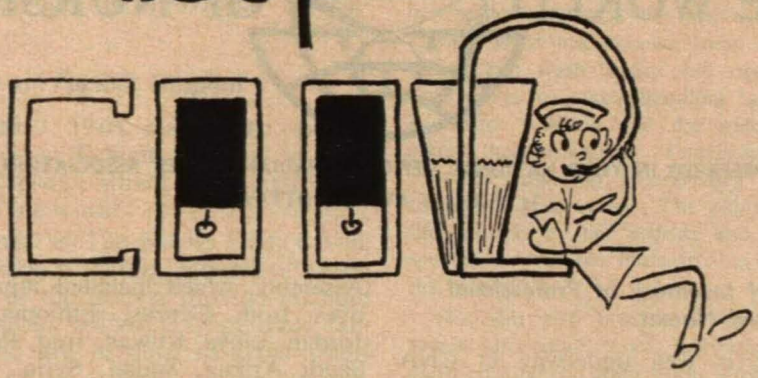
At the time of discharge, Mrs. Bell stated that the pain had disappeared completely, although there was slight numbness in the right leg at times. The doctor assured her that this would eventually disappear. She was a very happy woman when she said good-bye to us and returned to her family and friends.

R. N. Boners

The child may be uncooperative, but the nurse may obtain cooperation by using a little tack.

Certified milk is milk from cows that have been government-tested and then put in bottles and sold.

Keep



G. ZILM

Hot and bothered about the heat, nurse? Good! Overheating is a common disorder in hospitals — and there is something that you can do about it!

The normal body temperature of a human being, independent of environment, is around 97°-99°F. This narrow range is a balance between *heat gain* and *heat loss*.

Body heat is produced by catabolism of foods; it can, therefore, be influenced by anything that affects body metabolism — such as diet, exercise, etc. Body heat is lost mainly by conduction, radiation and evaporation of water from the skin.

Since most hospital administrators still regard air conditioning in patient areas as a luxury, the maintenance of a pleasant, comfortable and healthful summer environment usually remains a nursing problem.

Small, but significant measures can cool off a ward quickly: Remove the warm appearance of a room by storing blankets and heavy equipment out of sight during the day; open windows (on shady side of building) at both top and bottom and create a current of air; set fans in windows facing *out* to help circulate the air inside a room; pull shades against the hot sun; turn out the lights — dim natural light *seems* less hot; keep the rooms tidy — a tidy room looks cooler.

Certain nursing "touches" can help cool your patient: Roll up the sleeves of his hospital gown; encourage female patients to freshen up with cologne sticks or sprays; find or make some old-fashioned hand fans; force fluids — iced drinks for *psychological* coolness, warm drinks for physiological coolness; keep diet light — encourage fruits and vegetables where possible.

A most important weapon in the fight to beat the heat is a "cool-as-a-cucumber-you." This is the time for cool efficiency: wear uniforms with looser waistbands and made of cotton — since cotton is cooler than nylon; start your mornings with a lukewarm shower; bring fresh fruit for coffee breaks; put powder in your shoes; keep astringent-moistened face-pads (similar to those used for travel) handy in your purse for a lunchtime refresher. Remember, when you look cool, you have a psychological effect on others.

And never, *never* talk about the heat! Talking just reminds you and everyone else to be hot under the collar.

Perhaps, if you succeed in your hypothermic efforts, some warm-hearted patient may say: "This is a *real cool* ward, nurse!"

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

National Inventory of Professional Registered Nurses

Work is well underway in CNA National Office on the national inventory of professional registered nurses, which will, when complete, enable CNA to assess educational, employment and other nursing needs on both a provincial and national basis, and to make possible selective studies of specific areas of nursing or groups of nurses.

Since the Questionnaire, developed by GLENNA ROWSELL and other National Office staff members, appeared in the August and September 1963 issues of *The Canadian Nurse* (also mailed to registered nurses who were not members of RNAO and new members of RNABC) responses have been received from 26,000 nurses. The Questionnaires have been processed through IBM, compiled into 50 tables and analyzed. The published results of the analysis are now available.

Much work remains in evolving a national inventory but we are well on our way. In 1965, all provinces will be obtaining information on basic items and for the first time there will be comparable data on a provincial basis. In 1966, we hope to have this same information on a national basis.

CNA Executive Director in Lebanon

DR. HELEN K. MUSSALLEM presented a paper in May on "Trends in Nursing Education — Problems in Establishing and Maintaining Standards," to the Middle East Assembly of doctors and nurses. Details of the Assembly, which included representatives from Cyprus, Ethiopia, Iran, Jordan, Libya, Kuwait, Iraq, Pakistan, Saudi Arabia, Sudan, Syria, Turkey and the United Arab Republic, will be available in next month's issue. Dr. Mussallem also made a four-week survey of schools of nursing in Lebanon, which will result in recommendations to the government relative to the improvement of nursing education in that country.

Nursing Research Index

Over 130 completed studies on nursing have been coded and classified in National Office. The classifications as to content and the approximate percentage of studies in each category are as follows:

Category	*Approximate Percentage of Total Studies*
A. Historical, Philosophical and Cultural	.8
B. Occupational Research	10.6
C. Organizations for Nursing, Professional and Occupational	3.0
D. Administration of Nursing Service	40.9
E. Nursing Care	14.4
F. Education for Nurses	30.3

A listing of these studies giving the title, name of director, sponsor, and availability of the report, has been published and is available from National Office. A more comprehensive account of each study, outlining the purpose and methodology has been prepared and is now in publication.

University Brochure

A brochure on Canadian university programs in basic nursing education is ready to come off the press and will be available from National Office in a few weeks. They will also be available through the provincial associations.

A First at Fulham Hospital

March 3, 1964, marked the opening of a unit at Fulham Hospital in London, England, which is the first of its kind in the world.

Known as The Sterile Unit, it will, in addition to curing patients of a rare tumor of the uterus, provide facilities for patients suffering from renal failure who are in need of renal transplants or an artificial kidney for survival. It will also provide nursing training in sterile ward units as well as valuable new experience in the construction and running of permanent sterile departments.

The unit is housed in a temporary building (Fulham Hospital is due to be demolished in the course of the next few years to make way for the building of a new 850-bed teaching hospital) and combines the cleanest possible isolation accommodation with acceptable living conditions for patients who may need to remain in virtual seclusion for periods up to six months. It provides a series of single wards isolated bacteriologically from the outside world, yet enables patients to take some part in the life inside and outside the unit.

The wards are placed in line between two passages, both lit with daylight through the ceilings, enabling patients to see into both passages through double-glazed windows with venetian blinds between the glass. Patients are also able to look across one of the passages and into the street, but will not be unduly exposed to view from outside.

One of the two passages will be accessible to patients' visitors who will be able to talk and see through a clear polythene membrane without risk of infection entering the ward. Flowers can be put on wide ledges where they can be seen from inside. Trays, bedpans, dressings, etc., will be removed from the same passage by means of sealed double lockers. The other passage is for staff. It can only be reached by passing through changing rooms where they will wash and change into clean uniform. Ultraviolet light may also be incorporated in the changing rooms. Another polythene window is provided next to the Sister's desk so that the doctor can talk to her without entering the sterile area.

Each ward has its own toilet and wash basin. The wash basins are operated by foot valves to avoid handling taps before and after washing and the water is premixed thermostatically. Television sets are provided high up where they are seen through a glass screen. The patient has all the controls by her bedside and the loudspeaker is over the basin in the vicinity of the picture.

The unit also provides a sitting room, special procedure room, laboratory, office, wash-up kitchen, preparation kitchen, men's changing room, women's changing room, sterilizing room, bathroom, store and washroom, weighing room, cold room, and tissue culture room.

The unit was made possible through the efforts of the Ministry of Health, the Board of Governors of Charing Cross Hospital and the Wellcome Trust.

ICN Grand Council and Congress

The German Nurses' Federation has agreed not to limit the number of student nurses wishing to attend the ICN Grand Council meetings and the 13th Quadrennial Congress to be held in Frankfurt/Main, Western Germany, June 1965.

Student nurses wishing to go to Frankfurt, should apply for Registration Forms A and B, which are available from the CNA National Office.

Accommodation facilities for student nurses in Frankfurt will be provided by the German Nurses' Federation at a limited cost. It is hoped that an international meeting will be arranged for all students attending the Congress with the aim of promoting friendship and better understanding among the students of the world and to give them the opportunity of exchanging views of their training and professional experience.

The ICN looks forward to welcoming, to this international event, student nurses from all countries

where the National Nurses' Association is in membership with ICN.

Colombia University Grants First Nursing Degrees

The degree of *licenciada en enfermeria* was conferred on 11 candidates recently when the National University of Colombia Faculty of Nursing graduated its first class of basic baccalaureate nursing students.

The school in Bogotà has been assisted by the faculty of the Catholic University of America School of Nursing under a two-year Agency for international Development Contract. Seven Catholic University faculty members have been in Colombia during the past two years, assisting faculties to build curriculum standards. Dean of the faculty of nursing at the National University of Colombia, who brought this program to the university level, was Iñes DURANA.

New Standards of Nurse Training in Nigeria

At its July 1963 meeting, the Nursing Council for Nigeria received a report on "New Standards of Nurse-training in Nigeria" prepared by a special committee appointed to study this subject and make its recommendations. In view of the importance of the content and its significance for all nurses in the country it was agreed that an opportunity should be provided for trained nurses to meet to consider the implications of the report. Approximately 100 nurses from all parts of Nigeria attended a seminar arranged by the Nursing Council of Nigeria on October 11 and 12, 1963 at Lagos University Teaching Hospital. Their recommendations were submitted to the special committee and also to the Regional Nursing Committees when they met to study the original report. A supplement to the Report was prepared for presentation to the Nursing Council of Nigeria at its January 1964 meeting and it is hoped that a new committee with new terms of reference will be formed to consider ways and means of implementing the final recommendations for new standards of nurse training in that country.

Among those attending a curriculum-planning meeting in Edinburgh for the International School of Advanced Nursing Education to be set up at Edinburgh University are: DR. HELEN MUSSALLEM, *Executive Director, CNA and* MISS LYLE CREELMAN, *Chief, WHO Nursing Unit, Geneva.*

Nursing Profiles

Sister Mary Benedicta has returned to her position as director of the school of nursing, St. Joseph's Hospital, Peterborough,

(The Roy Studio, Peterboro)

SISTER M. BENEDICTA

Ont. She recently completed requirements for her M.S.N. from Catholic University of America, Washington, majoring in administration in nursing education and with a minor in psychiatric-mental health nursing. Sister obtained her baccalaureate degree from St. Francis Xavier University, Antigonish and a certificate in teaching and supervision from the School of Nursing, University of Toronto. She is a member of the Council of the College of Nurses of Ontario and of the Coordinating Committee of the Quo Vadis project.

Names in the News

Ella Baird, founder of the Hamilton Occupational Health Nurses Association, was presented with a gift and an honorary life membership in the Association by Sarah Wallace, senior nursing consultant, Department of Industrial Hygiene, Toronto, at the annual management-nurse-doctor dinner held in Hamilton earlier this year... **Margaret Mackenzie**, a graduate of Toronto Western Hospital, has been appointed director of the Quo Vadis School of Nursing—an experiment in nursing education for women

(Tom Bochsler, Hamilton)

SARAH WALLACE and ELLA BAIRD

over 30 years of age. The school is located in premises provided by St. Joseph's Hospital, Toronto, but is administered independently and financed by the Ontario Hospital Services Commission. Miss Mackenzie has recently returned to Canada after 10 years in the service of the World Health Organization... The Trained Nurses' Association of India has announced the appointment of a new general secretary and editor of the *Nursing Journal of India*. **I. Dorabji** has replaced **Kumari Lakshmi Devi** who held the same position for the past 14 years. Lakshmi Devi plans to take up residence in Wellington, New Zealand, as editor of the *N.Z. Nursing Journal*. We extend our congratulations to both of them.

A LOOK AT PROGRAMED LEARNING

— the educational technique that TIME *referred to as "the first real innovation in teaching since the invention of movable type in the 15th century."**

In 1954, Harvard's famous psychologist Dr. B. F. Skinner, often known as "the father of programed learning," conducted a series of "conditioning" experiments in which he taught pigeons to play pingpong and rats to press levers. By rewarding the pigeons and rats with food each time they made a correct response, and by teaching them a "step-at-a-time," the psychologist eventually had them showing the behavior that he wanted them to show.

Dr. Skinner's research developed the concept of what he called "positive reinforcement" — rewarding the elicited behavior.

According to Dr. Skinner, this principle can be applied to almost any type of human learning. He believes that any subject can be taught effectively to a human being in "half the time with half the effort" by using "programed learning."

Principles of Technique

1. Material for teaching must be carefully planned into logical sequence.
2. This material should be presented to the student in small amounts.
3. When he has mastered one step, he is asked to make some active response to show his understanding.
4. If he is right, he is at once told so, and presented with the next fact; if he is wrong, he is given an additional explanation before being questioned again.
5. This process goes on at a pace decided by the student. The bright work quickly, the rest work slowly, but all cover the same ground.†

It is emphasized that this type of teaching *supplements,* rather than replaces the work of the teacher.

In its original and still most popular form, the technique of programed learning makes use of teaching machines. The subject or "program" is broken down into "frames" which are exhibited one by one on the machine. The student writes his response to the question in the space provided and then pulls a lever to see if his response is correct. He pulls the lever again to move on to the next "frame." Each frame supplies information which supplements the previous frame.

The prices of the various machines available on the market vary; most, however, are too expensive for the average educational institution to buy in quantities. Several large companies have marketed "programed books" to take the place of the machine. The student simply turns a page to find out if his response to a question is correct. One company has programed books available for the entire high school curriculum.

Construction of Programs

Advocates of programed learning may not agree as to what subjects may be taught effectively by this method. They do, however, agree that the constructing of such programs is exceedingly difficult and time-consuming. Recently, a workshop sponsored by the Canadian Council for Programmed Learning was held in Toronto for persons interested in learning to con-

*"Programed Learning," *Time*, Mar. 24, 1961, p. 56.

†Winnifred E. Hector, "For and Against Programed Learning," *Nursing Times*, Jan. 17, 1964, p. 85.

FRAME	CUE AND ANSWER
29. When a glass of water is being filled and it overflows, it does not become empty. The overflow is usually only a small amount and stops as soon as the glass is able to hold the remaining water. A patient suffering from retention with overflow voids only a _____ amount of urine at a time.	not large small
30. The glass of water will soon overflow again if you continue to add water slowly. Urine is produced at about the rate of one drop per minute. Therefore, a full bladder will overflow frequently, The patient will void _____ in small amounts.	f_____ frequently
31. A patient is suspected of having retention with overflow if he voids _____ in _____ amounts.	frequently, small

— *Nursing Outlook, Vol. 11, No. 8, Aug. 1963.*

struct programs. This type of instruction is essential since the writing of programs is a highly skilled art that requires more from the teacher than a mere jotting down of questions on a piece of paper.

Application to Nursing

Can programed learning be applied to nursing? The answer would appear to be in the affirmative — provided that meaningful programs for the various subjects can be constructed. One programed book now available is Marie M. Seedor's *Introduction to Asepsis, A Programmed Unit in Fundamentals of Nursing* (distributed by J. B. Lippincott Co. of Canada, Ltd.).

Certain subjects in the nursing curriculum would seem to be innappropriate as programed subjects. For example, it is difficult to imagine how a programed unit concerning interpersonal relations could be particularly effective (on the other hand, one wonders just how effective *other* methods are of teaching this nebulous subject). The programing of material involving motor skills also presents problems.

We simply do not know the contribution of verbal learning to motor skill . . . . It seems unlikely that a student can learn effectively to give an injection without the opportunity to handle a needle and syringe. Similarly, a student needs practice in putting on sterile gloves even though she has an exact verbal knowledge of the procedure. Our experience has shown, however, that practice materials are not always as essential as we had believed.**

Improving Education

At a recent conference in Canada, Dr. Skinner presented more of his ideas concerning education in an address "How Can We Improve Education?" He stated that the *learning process* must be taken into consideration when developing methods of teaching and that teachers must concern themselves with the motivation of the student.

"At present, as in the past," said Dr. Skinner, "our whole educational system is based on the 'punishment theme.' Students study to avoid the consequences of failing. We give additional work as punishment. What teacher ever gave extra work to a student as a reward? Apathy and a general lack of enthusiasm are generated by this punitive system and result in a high incidence of student drop-outs."

**George L. Geis and Maja C. Anderson, "Programed Instruction in Nursing Education, Part 2," *Nursing Outlook*, Sept., 1963, p. 663.

When asked about methods of testing, Dr. Skinner left no one in doubt about his beliefs.

Multiple choice questions are the *evil* of today's educational system. They should *not* be used. One reason is that they deprive the student of the opportunity to compose sentences. Another is that there is a difference between *knowing* something and merely *recognizing it*. For example, if asked to translate a sentence into French, I would, no doubt, be unable to write it correctly; on the other hand, if given several sentences and asked to choose the correct one, I am quite certain that I could identify it.

Conclusion

Although programed learning is still a controversial subject among educators, its results are quite convincing. One educator recently stated:††

Undoubtedly, programed learning materials will be used increasingly in the future . . . . They will break away from the present standard format and will employ a variety of media and a variety of methods . . . . They will be organized in small units and will form an important part in an instructional system that will make provision for many types of learning situations — such as large group presentation to introduce a new topic, individual work by the student and periodic tests.

It will be interesting to see what use the nursing profession makes of this relatively new educational technique in the future. Its effectiveness will no doubt depend on the quality and availability of programs and the degree of enthusiasm generated by the nurse educators themselves.

V.A.L.

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††W. Bruce Adams, *School Progress, Dec., 1963.*

In Memoriam

Florence Elizabeth Carter (University of Alta. '46) died in Vancouver late in 1963.

* * *

Lucy Grace (Crealock) Charlton (Regina Grey Nuns' Hospital '32) died in Winnipeg early in January 1964. She was on the staff of St. Boniface General Hospital, Man. for the past four years.

* * *

Jessie (McCann) Cole (Halifax Children's Hospital) died recently. She was supervisor of nurses for the Cobequid Division of the Department of Public Health for several years.

* * *

M. E. Cowie (Montreal General Hospital '24) died suddenly in Canso, N.S. late in 1963.

* * *

Johanna Geertruida de Feyter (Lichtenberg Ziekenhuis, Amersfoort, Holland '37) died in Victoria early this year. She was a former staff member of the local Veterans' Hospital.

* * *

The Alumnae association of the Victoria General Hospital, Halifax pays tribute to the memory of the following graduates: **Frances (Thomas) Forrest** '98, who was one of the first nurses to join the Victorian Order of Nurses, a charter member of the Registered Nurses' Association of Nova Scotia and its first president; **Florence MacQueen** '15 who retired from nursing in '48.

* * *

Tribute is paid to the memory of the following graduates of Cobourg General Hosital, Ontario: **Pearl Irene Gallagher** '14, a former staff member of County of Bruce General Hospital, and **Edna Mary (Lean) Mellow** '22.

* * *

Henrietta (McFarlane) Heatherington (Owen Sound General and Marine Hospital '32) died late in 1963.

* * *

Verna E. (Morgan) Huether (Victoria Hospital, London '30) died January 4 ,1964. She had engaged in private nursing for part of her professional life, and was a former staff member of Beck Memorial Hospital, London and Toronto Hospital, Weston.

(Continued on page 683)

IN A CAPSULE

TRACHEOSTOMY CARE

Proper aspiration of secretions involves more than insertion of a catheter into the tracheostomy cannula. Common mistakes include inadequate aspiration, over-vigorous movement of a catheter within trachea and bronchus, and prolonged, intense suctioning.... To aspirate the patient's left main bronchus, the nurse turns his head to the right and tilts his chest to the left. Head is turned left, chest tilted right to aspirate the right main bronchus. There is no one preferred position for the patient although semi-Fowler's position may be helpful....

In most instances, one should gently insert the tracheal catheter as far as it will go, and deep enough to stimulate coughing. Because the *carina trachea* (ridge across bottom of trachea that marks branching of trachea into right and left main bronchi) is the most sensitive area in the respiratory tract, suction at the carina will initiate the liveliest coughing. Suction should be applied intermittently as the catheter is slowly withdrawn. The nurse must remember that a catheter in the trachea is an obstruction to the airway and should be withdrawn gently as soon as coughing is initiated. Otherwise, forced expiration against the catheter may increase positive pressure within the chest and interfere with cardiac circulation. — Totman, L. E. and R. H. Lehman. Tracheostomy Care. *A.J.N.*, 64:97, 1964.

DRUG PATENTS

Why should patents be given for drugs? Patents are granted to reward invention, and so encourage inventors to both discover and manufacture the products.

There is a tendency to believe that drugs should be treated differently from other inventions — because of the nature of the product. But this is an area where it is of the highest importance to encourage invention. Both the national health and the national economy can benefit greatly from successes in this field. Manufacturing is encouraged by a strong patent system. New drugs are the result of large expenditures on research. Without the incentive of patent protection, companies just would not engage in such research.

Abolishing drug patents would have little influence on the retail cost of good drugs. However, many more imitation and second-rate products would soon appear on the market. Thus both the quality and reliability of the drugs available to Canadians would be endangered. Italy, the only western country without pharmaceutical patents, is now planning to introduce them. Almost all important drugs have been discovered in countries with strong patent laws. — *New and Views*, 1:13, No. 1

G.I. MOTILITY POSTOPERATIVELY

It has long been thought that after an operation involving opening of the abdomen, all gastrointestinal motility ceases for a while. Wells and his colleagues from Liverpool (*Lancet*, 1:4, 1964) have evidence obtained from studies in humans and dogs to show that this is not so....

These researchers found that small intestine activity could continue almost without interruption after major abdominal surgery; that in most cases it never disappeared for more than two or three hours.

Barium bolus studies demonstrated that intestinal movement was indeed retarded after opening the peritoneum and even more after operation on the stomach or gallbladder. Delay seemed to be mainly due to slow emptying of the stomach, this being related to the length of anesthesia and the extent of the operation. The small intestine seemed to function fairly normally, but the colon was particularly passive, with the accumulation of gas within the first 48 hours. The authors consider that the colonic immotility is mainly responsible for any abdominal distention occurring postoperatively. — *C.M.A.J.*, 90:798, Mar. 28, 1964.

A MEMORIAL CHAPEL

ELVIE M. FOLLETT

Something relatively new is becoming a significant part of hospital life. In keeping with the philosophy of medicine and nursing that the patient's total needs — physical, mental and spiritual — should be met, some hospital boards have set aside a room where the patient, his family and his friends may find peace of mind, comfort, strength and courage. At the Toronto General Hospital it is known as the Quiet Room. At The Toronto Western it is the George R. Warwick Memorial Chapel, conveniently located on the main floor, an oasis of quiet and repose in the midst of the ceaseless activities of a large institution serving a large section of the community.

This chapel is the gift of four daughters, honoring the memory of their father who had been a member of the Board of Governors of The Toronto Western from 1914 until his death in 1956. It is simply and beautifully appointed. To the right of the entrance there is a centre aisle leading up to a low platform with a small altar over which a slender cross is placed. A narrow pulpit holds a leather-bound Bible. On either side of the aisle are three pews with appropriate racks provided with hymn books. A slender, high-backed pulpit chair and, at the back, a pew-like settee of simple design complete the furniture. The altar, pulpit and chair are of Brazilian rosewood. A communion set is part of the chapel equipment.

The walls, like the pews and settee, are of American cherry wood, with an eggshell finish on the wing walls flanking the altar, and on the ends of the pews. Soft draperies of granite sheer fall in gentle, graceful folds over the large window. A smaller window has a triple Gothic panel of vivid blue plexiglass. This same material is used in several spaces of the latticed floor-to-ceiling cherry wood screen that divides the entrance from the main sanctuary. The wall-to-wall carpet is a dull burnt-orange shade. These simple but effective features give an ecclesiastical atmosphere to the small chapel without in any way diminishing its size. To the left of the entrance there is a small vestry or changing room for the use of the clergy. The plaque on the outside wall reads:

The George R. Warwick Memorial Chapel
Come unto me all ye that labour and are heavy laden and I will give you rest.

A small rack holds beautiful little folders for distribution, giving the names of the benefactors and a brief explanation of the use of the chapel. It is open daily from 9:00 a.m. to 5:00 p.m. and is made available at any other time upon request. It may be used by people of all faiths. For those for whom the Cross is not an integral part of their religious observances, it can be removed for a particular service.

The chapel has been used freely. From time to time student nurses have been seen there in prayer and meditation. Nursing assistants, other staff members and visitors have entered, some for a few moments of quiet and Bible reading, some to linger a little longer. On Armistice Sunday 1962, there was a short but impressive service with a small choral group of nurses leading the singing. About 30 people attended, among them a number of ambulatory patients. The service was repeated in 1963. Christmas services have been held each year on the Sunday preceding Christmas, with a good attendance, again including patients in wheel chairs.

The chapel has been used for a wedding as well. The bride's mother was a patient, scheduled for surgery in two days. A request was made and granted for use of the chapel so that she could attend her daughter's wedding. Some time later a note of thanks, accompanied by a photograph of the happy couple taken in the chapel, reached the hospital and was placed on file in the "Album of Hospital Events."

An item in the chapel folder reads:

> It is to be used for worship, prayer and meditation. The Governors of the hospital and the benefactors who have made this place possible hope that those passing through hours of trouble and deep concern may find a refuge and a haven of comfort within its walls.

About Books

Quest in Medicine by Gordon Murray, M.D. The Ryerson Press, Toronto, 1963.
Reviewed by Dr. E. G. O'Brien, St. Mary's Hospital, Montreal.

This volume is intended as a sequel to a previous book by Dr. Murray, *Medicine in the Making*. The two works cover his career in teaching, clinical surgery and research at the University of Toronto and the Toronto General Hospital.

Although he intends the book primarily for lay readers, it should prove interesting reading for nurses, doctors, medical students and other paramedical personnel. In the early chapters, Dr. Murray covers his "behind the scenes" work with the artificial kidney, kidney transplants and some of the earliest cardiovascular surgery. In the last half of the book he reveals the catholicity of his interests in the field of surgery. We are given interesting glimpses into many problems. The reader's attention will be held until the last page has been turned.

These two books give ample evidence that Dr. Murray's life has been a true quest in medicine.

Physiology and Anatomy by Esther M. Greisheimer, B.S., M.A., Ph.D., M.D. 894 pages. J. B. Lippincott Co., Montreal. Ed. 8. 1963.
Reviewed by Miss Isobel Dreschner, Teaching Staff, School of Nursing, Toronto General Hospital, Toronto, Ont.

This book is considered a reference text: "As much or as little as may be desired may be selected for study." It is written with the design to supplement any student's general knowledge, "for whatever career he pursues."

In the eighth edition, additional information about cellular anatomy and physiology and many of the advances that have been made along other lines bring the text up-to-date with current thinking.

The discussion of body systems proceeds in a logical order from the simple to the more complex. After a brief introduction to anatomy and physiology, the musculoskeletal system is considered first in order to visualize man as an erect and moving being. A discussion of the anatomy and physiology of the nervous system and of the senses precedes that of all other body systems. It becomes evident that an understanding of the mechanisms that maintain the metabolism of the body presupposes a knowledge of the system that integrates and controls these.

A videograph of the anatomic relationships of the human body, many simplified illustrations and diagrams, that enhance the understanding of physiological processes, prove to be valuable learning aids. Examples from everyday life help to illustrate and simplify what is happening in physiological terms.

The practical considerations at the end of each chapter are of particular value to health workers who are in frequent contact with deviations from the normal. They have been revised and enlarged in this edition. A few common disorders and the effect of trauma in relation to the different body systems are noted. Some information about medical diagnosis, palliative and curative therapy as well as the body's own ability to restore balance and order is also included. The author's practical considerations should enhance every reader's understanding and appreciation of the wonderful way in which the human body is made and functions.

This book is not written specifically for nurses. Nursing instructors may have to be very selective in its use when planning a course for a first-year student, but may also have to consult the reference section in the back of the book for supplementary information when dealing with the graduating or post-basic student.

This text stresses the anatomy and physiology of the adult. In a few instances factors related to age or development are mentioned. Some sections briefly discuss the embryological stage of a body system. The book would be of limited value in nursing courses that emphasize an understanding of growth and development.

The text is simplified but not simple. It presents a challenge to the student who is uninitiated in this field of study. The author merits appreciation for her careful selection of all the new knowledge that is essential to a basic understanding of physiology today. She has presented her sub-

ject matter in a clear and meaningful fashion that helps to visualize the human body as an integrated whole.

Public Health Nursing Practice by Ruth Freeman, R.N., Ed.D. 455 pages. W. B. Saunders Co., Phila. 1963.

Reviewed by Mrs. B. Hatcher, Assistant nursing supervisor, Health Department, Vancouver 13, B.C.

This third edition of Dr. Freeman's well-known text has been extensively revised to meet the needs of the present-day practice of public health nursing. In her preface the author points out the "giant step forward" that has occurred in nursing knowledge and practice since the publication of the second revision in 1957. She acknowledges, too, the trend toward more specialization of public health nursing in schools and occupational health. Chapters have been added covering these areas.

Although Part I of this text which deals with "The Pattern of Public Health Nursing," is largely based on the situation in the USA and is often quite dissimilar to our own, it does make an interesting comparison. There are enough similarities to make it worthwhile reading.

In a very detailed way this book covers three major areas of public health nursing: assessing needs for service, methods of giving service, and evaluating services rendered. Excellent material is given in chapters headed, "Individual and Family Health Counselling and Teaching," "Office Management, Records & Reports" and "Group work: Organization Phases."

There is a wealth of material for any public health nurse. The author has recognized very clearly the complexities of this field of nursing and the many skills necessary to carry out the work. She sees these skills as those of nursing itself and those which must be borrowed from other disciplines, such as medicine, social work, education, sociology and psychology. In acknowledging these requirements, Dr. Freeman has skilfully woven them into her text.

A Bio-Bibliography of Florence Nightingale compiled by the late W. J. Bishop, F.L.A. Completed by Sue Goldie, B.A. (Oxon). 160 pages. Dawsons of Pall Mall, London, for The International Council of Nurses, 1962.

Reviewed by Sister Irene Pépin, a graduate of Institut Marguerite d'Youville, Montreal.

This bio-bibliography, the result of long research made possible through the assistance of the International Council of Nurses, offers a complete list of Florence Nightingale's published writings. Extensive notes, describing and explaining the background to the works, add greatly to the interest and will prove of value to the nursing-professor, the researcher — in short, to every modern nurse interested in acquiring insight into the true sense of her profession. Indeed, Florence Nightingale's writings offer principles fully applicable to our present-day needs: authentic professional development, not mere technical training.

Though dedicated to nurses, this book will be of interest to representatives of other professions, for the contents embrace such diverse subjects as nursing, army hygiene and sanitation, Indian and Colonial welfare, hospitals, statistics, sociology, religion and philosophy.

Interacting with Patients by J. S. Harp, B.S., M.S., R.N. and Kenneth H. Larson, B.S., R.N. 282 pages. The Macmillan Co., N.Y. 1963.

Reviewed by Mrs. Jean Hemsworth, Director of Nursing Education, Glace Bay General Hospital, Glace Bay, Nova Scotia.

The purpose of this book is to teach the importance of oral communication between patients and other personnel, especially nurses.

The first chapter appears to be rather technical for student nurses. They would not have the knowledge of psychiatry that this chapter would seem to demand.

The illustrative clinical material is of interest inasmuch as it serves to introduce the reader to the problems and type of conversation to be encountered when dealing with mentally disturbed persons. The degree of disturbance runs the whole gamut from the normal medical, surgical or obstetrical patient to the homicidal or suicidal patient. The techniques described are intended to invite the patient to express himself freely so that his inner thoughts become apparent.

It is a good book for intermediate and senior student nurses.

Morphogenesis by John Tyler Bonner. 296 pages. McClelland & Stewart Ltd., Toronto. 1963.

This pocketbook, written by the professor of biology at Princeton is an excellent study concerning development. Different organisms are grouped together and their development compared. The physics and chemistry involved in the developmental process are included.

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In Memoriam *(continued)*

Joan Valerie (Williams) Kruithof (Gray's Hospital, Pietermauritzberg, S.A. '55) died suddenly in Red Deer Municipal Hospital, Alta. late in 1963.

* * *

Bernadette Lépine (Sainte Justine Hospital, Institut Albert-Prévost) died early this year. She was the vice-president of Institut Albert-Prévost, Cartierville, Que.

* * *

Alice Nelson McConnell (Chipman Memorial Hospital, St. Stephen, N.B. '26) died early this year in Saint John, N.B. She had engaged in private nursing throughout her professional life.

* * *

The alumnae association of the Oshawa General Hospital pays tribute to the memory of: **Audrey (Powell) McKenzie** '37 and **Ruby (Denny) Remington** '33.

* * *

Euphemia Mitchell, Scottish-born graduate of a hospital in Liverpool, England died in Vancouver late last year. She was 80 years of age. Miss Mitchell served with Queen Alexandra's Nursing Corps during World War I and received the Royal Red Cross in recognition of her services. She came to Red Deer, Alta. in 1920 and practised her profession there until her retirement in 1952.

* * *

Marguerite Rita (Bates) Napier (St. Johns Long Island Hospital, New York '25) died late last year, She was a supervisor in the Halifax Convalescent Home.

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* * *

Pauline Nicole (Hôpital de l'Enfant-Jésus, Quebec '60) died last year as the result of an accident.

* * *

Muriel Margaret (Pierce) Orr (Woodstock General Hospital, Ont. '38) died late last year.

* * *

Stella Edith (Ford) Parrott (Ontario Hospital, Whitby '22) died in 1963.

* * *

Lucille Power (St. Joseph's Hospital, Glace Bay, N.S.) died recently at the age of 33 after a long illness. She was on the staff of the Victorian Order of Nurses, Sydney, N.S.

* * *

Jean E. (Zurbrigg) Roth (Brantford General Hospital, Ont. '32) died early in

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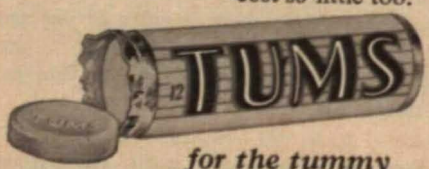

for the tummy

1964. She had engaged in institutional nursing.

* * *

Tribute is paid to the memory of the following graduates of Toronto General Hospital: **Elizabeth Allen (Roach) Justice** '52 and **Jean Ann (Warner) Massie** '59.

* * *

M. Pierrette R. St. Pierre (Hôpital Général du Christ Roi de Verdun '57) died recently.

* * *

Annie Schmalinsky, former supervisor at Muskoka Sanatorium, Gravenhurst and, most recently, superintendent of Bingham Memorial Hospital, Matheson, Ont. died on January 29, 1964.

* * *

Sister Simone M. Chauvet (Holy Cross Hospital, Calgary '45) died last year in Edmonton after a brief illness. She was night supervisor of St. Theresa Hospital, St. Paul, Alta.

* * *

Edna M. (Bustard) Shirley (Homeopathic Hospital, Montreal '41) died in Montreal late last year.

* * *

Edyth Stirrett (Taylor) Sideen (St. Joseph's Hospital, Port Arthur '31) died in Fort William, Ont. during 1963.

* * *

The alumnae association of St. Joseph's School of Nursing, Hamilton, Ont. pays tribute to the memory of **Sister Mary Gerard,** a member of the first graduating class of the school in 1915. Sister Gerard was operating room supervisor of her hospital for almost 20 years; administrator of St. Mary's Hospital, Kitchener for six years; administrator of the House of Providence, Dundas for six years. She died in August 1963.

* * *

Ann Brown Smith (Montreal General Hospital '18) died in November 1963.

* * *

Elizabeth (Chalmers) Van Valkenburg (City Hospital, Holyoke, Mass., 1900) died in Regina, Sask. after a long illness. Mrs. Van Valkenburg helped to establish the school of nursing in connection with the Regina General Hospital. She was an honorary member of the Saskatchewan Registered Nurses' Association.

* * *

Elizabeth (Hickson) West (Calgary General Hospital '48) died in Saginaw Michigan late last year.

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The Canadian Nurses' Association has not yet reviewed the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

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Senior Nurse, P.H.N. or B.Sc., preferred. Salary based on L.H.S. 5 scale depending on training and experience. Staff Nurses (2) immediately for duties in the Vermilion-Lloydminster-Derwent sectors, P.H.N. or B.Sc., preferred, but R.N.'s considered. Salary based on L.H.S. 5 scale depending on training and experience. Further information and enquiries from: Dr. R. B. Murray, Medical Officer of Health, Minburn-Vermilion Health Unit, VERMILION, Alberta. 1-90-3

Head Nurses for Medical Psychiatric and Intensive Care Units. A postgraduate course and/or at least 3-yr. experience in related service is desirable. Salary commensurate with qualifications and experience. Positions also available in a variety of services for **R.N.'s for Gen. Duty and For C.N. Aides.** Salary scale: Gen. Duty Nurses: $315 - $375; C.N. Aides: $210 - $250. Apply to: Assistant Personnel Director, Room 1409, Royal Alexandra Hospital, Edmonton, Alberta. 1-33-9

Registered Nurses full time (immediately) for new 100-bed Auxiliary Hospital. AARN recommended salary, liberal personnel policies. Contact: Nursing Director, Dr. Dan MacCharles Auxiliary Hospital, Box 998, Medicine Hat, Alberta. 1-64-2

General Duty Nurses for modern 60-bed fully accredited hospital situated 70 mi. northwest of Edmonton. Good personnel policies. Residence accommodation. For further particulars apply to: Administrator, St. Joseph's Hospital, Barrhead, Alberta. 1-3-1

General Nurses (2) for small General Hospital near Cold Lake Air Base. Good transportation to Edmonton. Minimum salary: $315. AARN policies. Apply: Matron, Duclos Hospital, Bonnyville, Alberta. 1-10-3

General Duty Nurses for well-equipped 76-bed hospital in active town of 3,000. Salary $315-$360 for Alberta registered; $305-$350 for non-Alberta registered. New separate residence, excellent personnel policies & working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta. 1-13-1

General Duty Nurses (2) for modern 25-bed hospital on Highway No. 12. Salary range $340 to $385. New staff residence. Full maintenance $35, personnel policies include Blue Cross, M.S.I. and pension plans. 21 days' vacation per year, plus statutory holidays. Apply to the: Director of Nurses, Municipal Hospital, Coronation, Alberta. 1-25-1

Graduate Nurses. Salary: $315 to $360/m. 5 day, 40-hr. wk., 31 days paid vacation after 12 mo. continuous employment, also generous sick time and pension benefits. For further particulars please apply to: M. Hawkes, R.N., Superintendent of Nurses, Municipal Hospital, Drumheller, Alberta. 1-31-2

NURSES fully qualified for 30-bed active treatment hospital. New hospital building and recently renovated nurses' residence. Unless definitely interested in coming, please do not apply. Personnel policies sent upon request. Apply to: Mrs. M. Hislop, Superintendent, Municipal Hospital, Bassano, Alberta. 1-5-1

BRITISH COLUMBIA

Clinical Instructors for Pediatrics, Urology and General Surgery in 450-bed hospital conducting a school of nursing with 190 students. Postgraduate preparation essential. Degree preferred. Current RNABC personnel policies in practice. Apply: Director of School of Nursing, St. Joseph's Hospital, Victoria, British Columbia. 2-76-5

Operating Room Head Nurse (Experienced, June 1st) with postgraduate course for modern accredited 82-bed hospital. Salary: $381-$460 according to experience plus RNABC allowance for postgraduate course. Accommodation available, 10 statutory holidays, 4-wk. vacation, superannuation and medical plan coverage. Apply: Director of Nursing, General Hospital, Kitimat, British Columbia. 2-36-1A

HEAD NURSE for small, active psychiatric unit in a General Hospital, associated with district Mental Health Clinic. University preparation desirable. Position open August first. For further information apply to: Director of Nursing, Kelowna General Hospital, Kelowna, British Columbia. 2-34-1

Head Nurse, male or female, for active Operating Room Unit. Postgraduate training required. Good personnel policies; residence accommodation available (female). Apply to: Director of Nursing, Trail-Tadanac Hospital, Trail, British Columbia. 2-72-1

Head Nurse for Recovery Room. University 1 yr. preparation in teaching and supervision preferred as well as experience in recovery room. Credit for experience and postgraduate preparation. Personnel policies in accordance with RNABC. For particulars write to: Director of Nursing Service, St. Joseph's Hospital, Victoria, British Columbia. 2-76-5A

Registered or Graduate General Duty Nurses for active 25-bed hospital. Salary B.C. registered $320 to start. Unregistered $305. RNABC personnel policies in effect, nurses' residence available. Apply: Administrator, Lady Minto Hospital, Ashcroft, British Columbia. 2-4-1

Registered Nurses or Graduate Nurses for 75-bed hospital opened in September 1962. Salary B.C. registered nurse $332-$404; salary non-registered nurse $317, RNABC policies in effect. Very active town in Cariboo Ranching country. Apply: Director of Nursing, Cariboo Memorial Hospital, Williams Lake, British Columbia. 2-80-1

General Duty Nurses (2) for 30-bed active hospital (Accredited) BCRNA policies in effect. Apply: Director of Nursing, Creston Valley Hospital, Creston, British Columbia. 2-16-1

General Duty Nurses for active 30-bed hospital. RNABC policies and schedules in effect also Northern allowance. Accommodations available in residence. Apply: Director of Nursing, General Hospital, Fort Nelson, British Columbia. 2-23-1

General Duty Nurses for 30-bed modern hospital 90-mi. east of Vancouver. Easy access to Fraser Canyon and Hope Princeton Highways. Modern nurses' residence available. RNABC policies in effect. Apply: Director of Nursing, Fraser Canyon Hospital, Hope, British Columbia. 2-30-1

GENERAL DUTY NURSES with B.C. registration for active 200-bed General Hospital with School of Nursing. Large expansion program under way. Personnel policies, including salary, in accordance with RNABC contract for 1964. Apply to: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia. 2-32-1

General Duty Nurses for fully accredited 82-bed hospital in northwestern B.C. 1964 salaries: B. C. Registered $347-$419, Non-Registered $332. Room and board $50/m, 10 statutory holidays, 1½ days sick leave, 4-wk. vacation, Superannuation and Medical Plan coverage. Apply to: Director of Nursing, General Hospital, Kitimat, British Columbia. 2-36-1

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—B.C. registered $347-$419; non-registered $332. Newly furnished residence with T.V. Good social activities, including bowling, curling, tennis and year-round swimming. Full personnel benefits including travel allowance. Apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia. 2-58-2

General Duty Nurses for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn and Hudson Bay Glacier. Initial salary $335, maintenance $50, 40-hr. 5-day wk., 4-wk. vacation. Boating, fishing, swimming, golfing, curling, skating, skiing. Comfortable nurses' residence, rail fare advanced if necessary. Apply: Sacred Heart Hospital, Smithers, British Columbia. 2-73-13

General Duty Nurses (2) for 17-bed hospital on West Coast of Vancouver Island. Salaries according to RNABC agreements. Personnel policies in effect, room and board in modern nurses' residence $40/m. Apply by mail or telephone to: Matron, General Hospital, Tofino, British Columbia. 2-71-1

General Duty and experienced Operating Room Nurses for 50-bed active hospital in northwestern B.C. 1964 salaries: B.C. Registered, $347, Non-Registered, $332. RNABC personnel policies in effect. Planned rotation. New residence, room and board: $50/m. T.V. and good social activities. Write: Director of Nursing, Box 1297, Terrace, British Columbia. 2-70-2

General Duty Nurses and Certified Nursing Assistants for new modern, 70-bed hospital, at Mile 47, Alaska Highway, 3-mi. from Airport. Policies for nurses in accord with those of the RNABC. Pop.: 7,000 — White. Sports summer and winter. Charlie Lake, 7-mi. Apply: Director of Nursing, Providence Hospital, Fort St. John, British Columbia. 2-24-1

General Duty and O.R. Nurses with postgraduate course or equivalent experience required for 146-bed General Hospital. Personnel policies in accordance with RNABC. Apply: Director of Nursing, General Hospital, Chilliwack, British Columbia. 2-13-1

General Duty, Operating Room & Experienced Obstetrical Nurses for 434-bed hospital with school of nursing. Salary: $332-$404. Credit for past experience & postgraduate training. 40-hr. wk. Statutory holidays. Annual increments; cumulative sick leave; pension plan; 28-days annual vacation; B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia. 2-73-13

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic rate $332/m with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia. 2-9-1

Graduate Nurses for modern 100-bed hospital in southeast B.C. Apply: Director of Nursing, Kootenay Lake General Hospital, Nelson, British Columbia. 2-47-1

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Graduate Nurses for General Duty, in medicine, surgery, obstetrics, pediatrics and operating room in new, modern 188-bed hospital in city (20,000) on east coast of Vancouver Island. Personnel policies in accordance with RNABC policies. Starting salary for R.N. — $332 approx./m. Apply to: Director of Nursing, Regional General Hospital, Nanaimo, British Columbia. 2-46-1

Operating Room, Obs. and General Duty Nurses for modern 450-bed hospital with a school of nursing. RNABC policies in effect. Salary $332/m. Credit for past experience and postgrdauate training. 40-hr. wk., 10 statutory holidays, Annual increments, cumulative sick leave, pension plan, 28-day annual vacation. B.C. registration required. For particulars write to: Director of Nursing Service, St. Joseph's Hospital, Victoria, Vancouver Island, British Columbia. 2-76-5

Nurses two for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home Apply to: Miss H. Campbell, R.N., Director of Nursing, Community Hospital, Grand Forks, British Columbia. 2-27-1

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MANITOBA

Registered Nurse required as Superintendent of fully modern 17-bed General Hospital, located in South Western Manitoba. For salary and full particulars, apply to: Miss L. K. Fraser, Sec.-Treas., Boissevain, Morton and Minto Memorial Hospital, Box 899, BOISSEVAIN, Manitoba. 3-11-1

Registered Nurses (2) for fully modern 17-bed hospital, congenial staff and an attractive residence area. Starting salary for experienced personnel: $340, less $45 for maintenance. 40-hr. wk. and excellent personnel policies including an available pension plan. For further information apply: John Hiscock, Secretary-Treasurer, District Hospital, Baldur, Manitoba. 3-4-1

Registered Nurses for regular staff and holiday relief in modern 20-bed hospital. Salary: $330/m with $15 increment annually for 4-yr. 40-hr. wk. 3-wk. vacation after 1 yr. Insurance plan and pension plan in effect. **Licenced Practical Nurses** are also required. Applications to be submitted in writing, stating qualifications and experience with reference to: Mrs. J. Adams, Matron, Memorial Hospital, Deloraine, Manitoba. 3-18-1

Registered Nurse with supervisory experience to assume duties of Director of Nursing, of a 25-bed hospital, 30-mi. from Winnipeg. Salary range $370-$415. Quarters available. For more detailed information write: Administrator, DeSalaberry District Hospital, St. Pierre, Manitoba. 3-53-1B

Registered Nurses (2)for 25-bed hospital, 30-mi. from Winnipeg. Commencing salary $325, 40-hr. wk., vacation pay, pension plan, 10 statutory holidays, sick leave with pay. $5.00 increment every 6-mo. Apply to: Administrator, DeSalaberry District Hospital, St. Pierre, Manitoba. 3-53-1C

Registered and Practical Nurses (immediately) for 18-bed hospital at Vita, Man., 70-mi. from Winnipeg. Starting salary, R.N. $330 - L.P.N. $225, with allowance for experience. Daily bus service. 40-hr. wk., full maintenance available for $50/m. Apply to: Matron, District Hospital, Vita, Manitoba. 3-68-1

General Duty Nurses (3) for new 85-bed hospital. Good salary and generous personnel policies. Apply: Director of Nursing, Portage Hospital District No. 18, Portage La Prairie, Manitoba. 3-45-1

General Duty Graduate Nurses (Pediatric Ward) for modern 70-bed hospital. Salary commensurate with experience. Good personnel policies. Bilingual community situated near Riding Mountains and the lakes. For more information, write to: Sister Superior, Ste. Rose General Hospital, Ste. Rose, Manitoba. 3-54-1

NEWFOUNDLAND

Registered Nurses for General Duty and Operating Room for 100-bed hospital. Newfld. Gov't. salary plus $150 bonus end of 6-mo. service. One way transportation paid, 2-wk. vacation after completion of 1-yr. 8 statutory holidays. Apply: Nurse-in-Charge, Notre Dame Bay Memorial Hospital, Twillingate, Newfoundland. 5-13-1

NORTHWEST TERRITORIES

Operating Room Nurse with supervisory ability for active 44-bed acute General Hospital. Salary according to experience. Accommodation available at hospital. Apply: Director of Nurses, Stanton Yellowknife Hospital, Yellowknife, N.W.T. 12-11-1

NOVA SCOTIA

Registered Nurses for 21-bed hospital in pleasant community — Eastern Shore of Nova Scotia. Apply: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbour, Nova Scotia. 6-32-1

TO: Registered Nurses
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General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia. 6-21-1

ONTARIO

DIRECTOR OF NURSING EDUCATION for 215-bed accredited hospital — 100 students — University preparation and experience required, degree preferred. Good personnel policies, position available June, 1965. Apply to: Administrator, Royal Victoria Hospital, Barrie, Ontario. 7-8-2

Instructor — Registered Nurse with teaching preparation and/or experience for Clinical Teaching with a nursing assistant program. For further information, write to: Director, Ontario Department of Health, Registered Nursing Assistant Centre, 31 Walnut Street South, Hamilton, Ontario. 7-55-16

Instructor for Medical-Surgical Nursing, student enrollment 150 in 3-yr. diploma program. **Also Head Nurse for Nurseries.** 40-hr. wk. 9 statutory holidays, excellent personnel policies. Apply stating qualifications and experience to: Director of Nursing, Women's College Hospital, 76 Grenville Street, Toronto5, Ontario. 7-133-51

In-service Education Co-ordinator for in-service and orientation program. Baccalaureate Degree preferred. Experienced Operating Room Head Nurse for 5-theatre operating room suite. Modern 230-bed General Hospital with a school of nursing. Excellent personnel policies. Salary will be commensurate with qualifications and experience. Apply to: Director of Nursing Service, St. Joseph's General Hospital, Port Arthur, Ont. 7-106-2

Registered Nurses for modern 166-bed General Hospital. Interesting general duty positions open in all areas. Starting salary (1964): $330/m., 37½-hr. work wk. Congenial atmosphere, excellent fringe benefits and personnel policies. Limited residence accommodation available. For further particulars write: Director of Nursing, Memorial Hospital, Bowmanville, Ontario. 7-14-1

Registered Nurses for new 65-bed hospital. Resort area. Salary range: $315/m. Up-to-date personnel policies. Apply: Director of Nurses, South Muskoka Memorial Hospital, Bracebridge, Ontario. 7-15-1

Registered Nurses for Surgical, Medical, Pediatric, Obstetrical, Departments and Operating Room, required by 100-bed General Hospital, situated in Northern Ontario. Starting salary $360, annual increments, good personnel policies, including 40 hours per week. O.H.A. pension plan and group life insurance, O.H.S.C. and P.S.I. plans in effect. Accommodation available in residence if desired. For further particulars apply to: Director of Nurses, Lady Minto Hospital, Cochrane, Ontario. 7-30-1

Registered Nurses applications are invited for Delivery Room and General Duty. Basic salary is $330/m. with credit for experience. Residence available. For further information write to: Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1A

Registered Nurses for 34-bed hospital, min. salary $350/m. — max. of $450 in five years, 3-wk. vacation with pay sick leave after 6-mo. service. **All Staff** — 5 day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

Registered Nurses for 25-bed hospital. Minimum salary: $350 with allowance for experience. Registered Nursing Assistants, minimum salary: $250 with allowance for experience. Excellent fringe benefits. Board and room available in residence: $45/m. Apply to: Mrs. G. Gordon, Superintendent, Nipigon District Memorial Hospital, 98 Churchill St., Nipigon, Ontario. 7-87-1

Registered Nurses for 47-bed hospital. Minimum salary: $340, 3-wk. vacation, pension, life and medical insurance. 8 statutory holidays, 40-hr. wk. Apply to: Director of Nurses, Porcupine General Hospital, South Porcupine, Ontario. 7-123-1

Registered Nursing Assistants for well-equipped 42-bed General Hospital located in area known for its wealth of natural resources. The sportsminded person has unlimited activities to enjoy. Starting salary: $230/m. Excellent personnel policies. Accommodation available in well-furnished nurses' residence. For further information please phone or write : The Director of Nursing, Sioux Lookout General Hospital, P.O. Box 909, Sioux Lookout, Ontario. 7-119-1

Registered Nurses, Certified Nursing Assistants (IMMEDIATELY) for 40-bed hospital in pleasant town of 5,000, 42-hr. wk. with good rotation shifts, providing long weekends every 4 wks. Good salaries and personnel policies. For further details and application, apply: Administrator, General Hospital, Espanola, Ontario. 7-41-1

Registered Nurses and Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $350 and $240 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Assistance with transportation can be arranged. Apply to: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses and Certified Nursing Assistants for immediate and future vacancies in this 42-bed hospital. Starting salaries $335 and $225, respectively. Accommodation in new residence available. Usual fringe benefits. For full information, apply to: Director of Nursing, New Liskeard and District Hospital, New Liskeard, Ontario. 7-83-1

Registered Nurses for General Duty in well-equipped 28-bed hospital, located in growing gold mining and tourist area, north of Kenora, Ontario. Modern residence with individual rooms; room, board and uniform laundry only $45. 40-hr. wk., no split shift, cumulative sick time, 8 statutory holidays and 28 day paid vacation after one year. Salary range $350 - $375. Apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

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Registered Nurses for General Duty in small sized General Hospital located 30-mi. from Ottawa. Good personnel policies. Apply: Superintendent, District Hospital, Kemptville, Ontario. 7-63-1

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80.000 people. **Salary: $335 per mo.**, with annual merit increments, plus **annual bonus plan**, 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury**, Ontario. 7-127-4

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario. 7-120-2

General Duty Nurses for 66-bed General Hospital. Starting salary: $335/m. Excellent personnel policies, pension plan, life insurance, etc., residence accommodation. Only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses $325-$355/m, Graduates $285-$325/m, 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

General Duty Nurses for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $325/m basic salary. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

General Duty Nurses for 325-bed fully accredited General Hospital located in downtown area of city. Planned orientation program. Progressive personnel policies. Apply to: The Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-133-9

General Duty Nurses & Certified Nursing Assistants for new 50-bed hospital with modern equipment. 40-hr wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, Meaford, Ontario. 7-79-1

Public Health Nurses (Qualified) for an urban-rural Health Unit. Salary range: $4,000 to $4,950, annual increment: $200 with allowance for experience. Apply: Director of Public Health Nursing, Simcoe County Health Unit, Court House, Barrie, Ontario. 7-8-3

Public Health Nurses (qualified) for general program. Salary range $3,900 to $4,800. 5-day-wk., 1-mo. vacation, car allowance, pension plan, 50% hospitalization, P.S.I. Apply to: Dr. E.A. Dunton, Director, Brant County Health Unit, Aberdeen Avenue, Brantford, Ontario. 7-17-4

Public Health Nurses (Qualified) for generalized program, by Stormont, Dundas and Glengarry Health Unit located in the Seaway Valley area. Minimum salary $4,000. Annual increment. Allowance for experience. 5-day wk. Employer-shared (50-50) group insurance, portable OMERS pension plan, Ontario Hospital Insurance and P.S.I. coverage (medical, surgical and obstetrical plan). 3-wk. vacation, cumulative sick leave credits, one-half paid as bonus upon leaving after 3-yr. service. Generous car allowance. Reply in writing to: Dr. John A. Thomson, Medical Officer of Health, Box 1058, Cornwall, Ontario. 7-34-5

Public Health Nurses (Qualified). Salary range $4,300-$5,300, required in a generalized program in rural and semi-urban area adjacent to Metropolitan Toronto. Excellent working conditions including pension plan, group insurance, and transportation arrangements. Write: Dr. R. M. King, York County Health Unit, 64 Bayview Avenue, Newmarket, Ontario. 7-84-2

Public Health Nurse (Qualified) for generalized program in small city health department. Salary: $4,000 to $5,000, P.S.I., 5-day wk., generous car allowance, 1-mo. vacation, accumulative sick leave. Apply to: Dr. A. S. Middlebro', Owen Sound Department of Health, 100 - 8th Street, East Owen Sound, Ontario. 7-94-2

PUBLIC HEALTH NURSES (qualified) for generalized program with City of Peterborough. Salary range $4,075-$4,850. Personnel policies available on request. Apply to: J.R. Anderson, M.D., D.P.H. Medical Officer or Health, City Hall, Peterborough, Ontario. 7-101-3

PUBLIC HEALTH NURSES: Salary $4,000 to $5,000, annual increment $200, allowance for experience. Hospital Plan, P.S.I., Pension Plan, sick leave, 4-wk. vacation, generous car allowance. Nurse will reside in a city of 46,000 population. Apply: Dr. W.C. MacPherson, Director, Port Arthur and District Health Unit, 93 Balsam Street, Port Arthur, Ontario. 7-106-3

Public Health Nurse (Qualified - Catholic).Minimum salary: $4,236. Annual increments. 5-day wk.; 4-wk. vacation; $100 uniform allowance; pension; P.S.I. Apply: Director, St. Elizabeth Visiting Nurses' Association, 99 Gloucester Street, Toronto 5, Ontario. Telephone: 925-8907. 7-133-60

Public Health Nurse for general staff duties. Basic salary: $4,200 with adjustment for experience. Personnel policies include employer shared Ontario Hospital Services, Windsor Medical and OMERS plan. Apply stating qualifications and experience to: Dr. W. H. Johnston, Medical Officer of Health, Department of Health, Chatham, Ontario. 7-24-3

STAFF NURSES FOR 220-BED ACCREDITED HOSPITAL with School of Nursing. Salary $325. Preference for any particular service given every consideration. Post-Basic Certificates recognized. Usual personnel benefits, plus proximity to Ottawa, Montreal and Northern New York State. Apply: Assistant Director of Nursing (Service), General Hospital, Cornwall, Ontario. 7-34-1

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 150-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda. 13-1-18

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Assistant Head Nurses and Certified Nursing Assistants for 60-bed children's orthopedic hospital. Excellent personnel policies. Apply: Miss Flora M. Lamont, Reg.N., Administrator, Shriners Hospital for Crippled Children, 1529 Cedar Avenue, Montreal 25, Quebec. 9-47-42

Registered Nurses for 30-bed General Hospital, 50 mi. from Centre of Montreal. Excellent bus service. Starting salary: $325/m. Salary increases as recommended by ANPQ. 40-hr. wk. Annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Que. 9-29-1

Registered Nurses and Certified Nursing Assistants for 115-bed hospital for tuberculosis and other chest diseases. Situated in the heart of the Laurentian Mountains, 55-mi. north of Montreal. Apply: Director of Nursing, Box 1000, Ste Agathe des Monts, Quebec. 9-57-1

Registered Nurses and Non-Registered Graduates from another province or country for chronic hospital. Salaries as per ANPQ, living-in accommodations can be provided. Appointments by telephone or write: Dr. M. Tardif, Executive Director, Jewish Hospital of Hope, 7745 Sherbrooke Street, East, Montreal 5. Tel. No. 352-3120. 9-47-13

SASKATCHEWAN

Director of Nursing for 15-bed hospital near Saskatoon. Some post-basic preparation preferred. Salary: $385-$450 depending upon qualifications and experience. Residence accommodation available for $34.50/m. Address inquiries to: Manager, Union Hospital, Delisle, Saskatchewan. 10-24-1

(A) Associate Director of Nursing Education. (B) Two Medical-Surgical Instructors. (C) Registered Nurses for Pediatrics. Experience recognized. Salary range in accordance with Saskatchewan Hospital Association recommendations. Prince Albert, Saskatchewan. The Gateway to vacation land. Apply to: Director of Nursing, VICTORIA UNION HOSPITAL, Prince Albert, Saskatchewan. 10-103-2

Registered Nurses for the Riverdale Memorial Union Hospital at Turtleford, Sask. Salary as recommended by SRNA. Excellent personnel policies in effect, nurses' residence located near the hospital, board and room available. The R. Memorial Union Hospital is a 20-bed hospital, modern throughout, good equipment and facilities, a further addition and a large renovation program has been approved. The hospital has two Doctors on staff, a clinic is situated near the hospital providing services such as Dentist, Physiotherapy, Optomotrist etc. Turtleford is a modern Village situated 50-mi. from North Battleford with daily bus service to N.B. and Saskatoon. Surrounded by a number of resorts. Please apply to: Sec.-Manager, R.M. Union Hospital, Turtleford, Saskatchewan. 10-125-1

Registered Nurses for Nursing Service and Nursing Education for 150-bed, accredited new hospital. SRNA personnel policies. Apply to: Director of Nursing, Holy Family Hospital, Prince Albert, Saskatchewan. 10-103-1

GRADUATE NURSES for 8-bed hospital in Southern Sask. Salary range $335-$425. Qualifications and experience considered. 3-wk. vacation plus statutory holidays, 40-hr. wk., modern residence with T.V. Personnel policies on request. Apply to: Mrs. D. L. Knops, Sec.-Treas., Union Hospital, Rockglen, Saskatchewan. 10-110-1

U S A

Registered Nurses for modern 374-bed General Hospital on the beautiful, warm Peninsula yet only 20-min from the heart of cosmopolitan San Francisco. Openings in all nursing services including operating room, emergency room, and I.C.U. Excellent personnel policies, many extra benefits and opportunities for advancement. Telephone collect, OXford 7-4061 or write: Director of Personnel, Peninsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary $395 with automatic increase to $455 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

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Registered Nurses for a new 60-bed Children's Hospital operated by Sisters of St. Joseph in Orange, California. California license required. Excellent salary and benefits. Write: Personnel Office, St. Joseph Hospital, Orange, California. 15-5-56

Fashion your career in nursing in any field you might desire—the choice is yours. At "Cook County", opportunity unlimited awaits you. Increase your knowledge and experience, pursue your special area of interest, grow with your profession. Here you feel the pulse-beat of nursing, its importance and the vital role it plays in the world of today. You make a wise decision when you join the staff of Cook County Hospital . . . it is, indeed, a solid foundation on which to build your future.

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Registered Nurses for private 278-bed hospital for men, women and children. Staff Nurse salaries from $400-$465, differentials for evenings and nights. Opportunities in all clinical areas. Holidays, vacations, sick leave, life insurance and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses for 233-bed modern hospital. Positions available — all services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area, equal opportunity employer. Apply: Director of Nursing Service, Kaiser Foundation Hospitals, San Francisco 15, California. 15-5-7

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $395 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

Staff Nurses for 300-bed County Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Staff Duty positions (Nurses) in private 403-bed hospital. Liberal personnel policies and salary. Substantial differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-3B

PROFESSIONAL NURSES For immediate openings in 274-bed General Hospital, liberal fringe benefits. Enjoy interesting, challenging position in the ideal climate of Santa Monica Bay. Apply: Director of Nursing, Santa Monica Hospital, 1250—16th Street, Santa Monica, California. 15-5-40

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

General Duty Nurses for various departments including surgery for 72-bed hospital. Starting salary $375 per mo. with periodic increases and fringe benefits. College town, tourist area, ideal climate. Contact: Superintendent, Lutheran Hospital Association, Alamosa, Colorado. 15-6-1

Executive Director generalized public health nursing agency. Potential for program expansion in rapidly growing community 45 minutes from NYC. Staff 8 full time, 5 relief nurses. Master's degree, administrative ability; experience required, salary open. Send résumé to Mr. Charlees H. Ulrich, Chairman, Personnel Staff Committee, Visiting Nurse Association, 60 Guernsey Street, Stamford, Connecticut. 15-7-4

REGISTERED NURSES: for 75-bed, air conditioned hospital, growing community. Starting salary $330-$365/m. fringe benefits, vacation, sick leave, holidays, life insurance, hospitalization. 1 meal furnished. Write: Administrator, Hendry General Hospital, Clewiston, Florida. 15-10-1

Help Wanted! Registered Nurse in sunny Florida near West Palm Beach. 40-hr. wk. Good working conditions New 50-bed hospital under construction. Living quarters available. S.E. end of Lake Okeechobee. Write or call: J. C. Simonds, Administrator, **EVERGLADES MEMORIAL HOSPITAL**, 1749 E. Main Street, Pahokee, Florida, 33476. Phone: 924-5502. 15-10-4

General Duty Nurses for 54-bed hospital, minimum starting salary $350 per mo., located near Miami and West Palm Beach. Apply: Director of Nurses, Belle Glade Memorial Hospital, Belle Glade, Florida 15-10-3

Staff Nurses (All Areas) Orientation and staff development programs, "nurse-saving" equipment, challenging working environment, individualized living accommodations in new air-conditioned cottages. Opportunity to participate in nursing practice of the finest quality in our 200-bed General Hospital, located along Lake Michigan shoreline, 30 min. from Chicago. Starting salaries $390-$410 plus $30 differential for 3-11 and 11-7. Write: Director of Nursing, Highland Park Hospital, Highland Park, Illinois for detailed brochure. 15-14-3

Staff Nurses and Licensed Practical Nurses (Openings in several areas, all shifts). Minimum starting pay $77 R.N.'s; L.P.N.'s $64 per wk, experience considered; differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth A. Byrne, R.N., Director of Nursing, Chelsea Memorial Hospital, Chelsea, Mass. 15-22-1

Staff Nurses 380-bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $350 per mo. even., night or O.R. with call; annual increases up to $410; days $340 per mo. with increases up to $400 Rotation from day duty is required only when no person desiring permanent P.M. or night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 5 yrs. — 3 wks., 10 yrs. — 4 wks. Active in-service program. Occasional vacancy hosp. owned appts. New Mexico licensure as professional nurse and U.S. citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611. 15-32-3

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General Staff Nurses registered in Ontario $335 - $400 per month. Registered Nursing Assistants $235 - $271 per month.

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For all Nursing Units including an Intensive Care Unit. Salaries — Registered Nurses: $320-$360; Registered Nursing Assistants: $210-$250 Progressive Personnel Policies, Pension Plan, Group Insurance

For further information write to:

DIRECTOR OF NURSING,

Dufferin Area Hospital, Orangeville, Ontario.

MALE OR FEMALE SUPERINTENDENT WANTED AS CHIEF EXECUTIVE OFFICER

For 22-bed acute General Hospital in a town of 1,600. Five doctors on staff. R.N. mandatory. Administrative experience desirable. Complete administrative charge of Hospital. Minimal bed-side nursing. Commence September 1st. Starting salary from $425-$500 per month, according to qualifications and experience. Excellent fringe benefits.

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Required by the City of Toronto,
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Qualified Public Health Nurses for Generalized Public Health Nursing Service, or Epidemiological Venereal Disease Service. Salary range $4,231-$4,787. Salary negotiations now in progress. Starting salary based on experience. Annual increments, vacation, shared hospital and medical insurance, sick pay and pension plan.

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FOR GENERAL DUTY IN MODERN 18-BED PRIVATE HOSPITAL IN IRON MINING TOWN
140 miles north of Sault Ste. Marie, Ontario

SALARY RANGE $330 MINIMUM TO $377 MAXIMUM.

Allowance for experience. Board and room available at $20 per month
Transportation allowance up to $50 after 6 months

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U.S.A.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

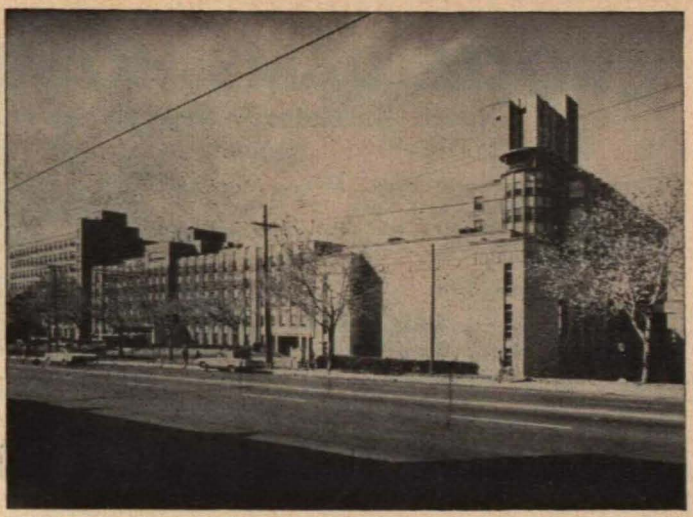
Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $410 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $387. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland, Oregon. 97201. 15-38-1

REGISTERED NURSES If you are looking for job satisfaction and educational opportunities, you can find both at Presbyterian Hospital in Philadelphia. General Staff positions in Cardiac-thoracic, Medical-Surgical, O.R., O.B., and Pediatrics. Eligible to work one year with Canadian License. Salary $4,080-$4,800/year depending upon experience plus $30-$50/m. for evening and night assignment. Half rate tuition at University. Write or call: Directress of Nurses, 51 North 39th Street, Philadelphia 4, Pennsylvania: Ev 2-4200, Extension 342. 15-39-1B

Assistant Science Instructor to teach in anatomy and physiology laboratory or microbiology and chemistry laboratories. Lectures given by Albright College professors. School has 6 nurse instructors to teach the laboratory portion of the course. 1 class/yr. Science instructors assist with medication supervision in the spring. Hospital now has 621 beds and is in an expansion program. Teaching and laboratory facilities excellent. School has full accreditation from N.L.N. Large school with no recruitment problem. There are 33 nurse instructors on faculty. School is being expanded. 7 new faculty positions to be added. Salary: $5,460 to $5,820. Opportunities for promotion. Full instructor salary: $5,820 to $7,020. Retirement plan in addition to social security. Hospital pays the retirement policy premium. After 3-yr. hospital provides life insurance policy for employee equivalent to 1-yr. salary. Hospital pays the premium. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath and shower. Latest teaching aides, including I.B.M. grading machine. Hospital located in a beautiful 40 acre park. Community has many cultural opportunities. 1 college in city. 4 universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Pennsylvania. 15-39-4

JEWISH GENERAL HOSPITAL MONTREAL QUE.



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In this modern 400-bed non sectarian hospital in Administration, Teaching, Staff Nursing, Certified Nursing Assistants also required. Openings in Psychiatry, Pediatrics, Obstetrics and Medicine and Surgery. Excellent personnel policies. Bursaries for post-basic courses in Teaching and Administration.

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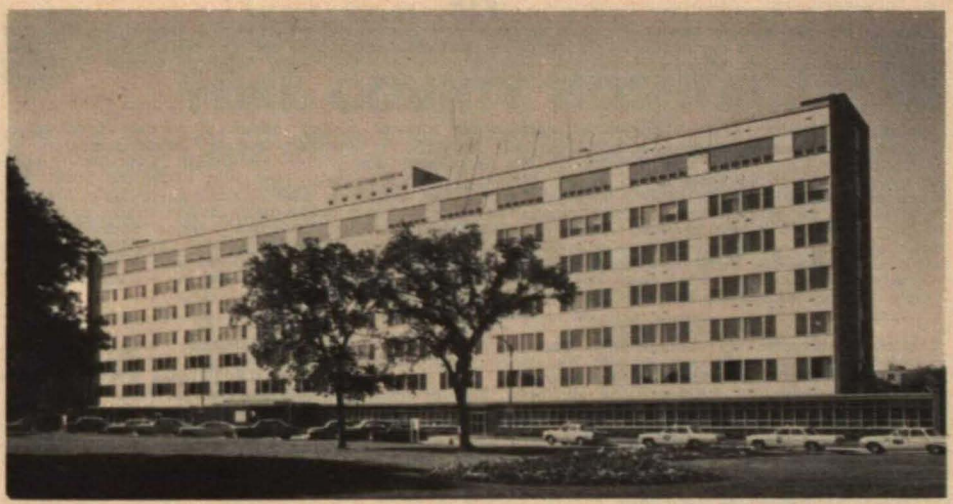

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North Battleford, Saskatchewan

REQUIRES

General Staff Nurses and Certified Nursing Assistants for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary range: R.N. $315 to $390, C.N.A. $205 to $235 gross per month. Differential for evening and night duty for R.N.'s. Accommodation close to hospital if desired.

Apply to:

DIRECTOR OF NURSING SERVICE
Notre Dame Hospital, North Battleford, Sask.

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Postgraduate Teaching Hospital of the University of London,
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If you are a Trained Nurse visiting London to further your experience in nursing

You are invited to join the staff of the above postgraduate teaching hospital of 90 beds. A high standard of surgical nursing in the wards and advanced technical methods in the operating theatre are offered to fully trained nurses. A biannual course of lectures is given on the specialized subjects of this hospital by the consultant staff for which a certificate is given on completion of at least six months satisfactory service. The hospital is situated in London close to many places of interest. Appointments may be resident or non-resident.

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U.S.A.

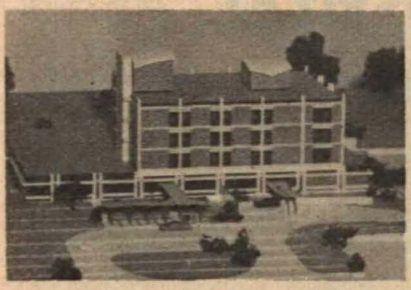
Assistant Director, Nursing Service. Excellent opportunity for nurse with administrative capabilities. Plan and coordinate nursing care on medical-surgical divisions. Baccalaureate degree and experence required. Progressive personnel policies. Salary commensurate with education and experience. Apply to: Director of Nursing Service, Mount Sinai Hospital, University Circle, Cleveland 6, Ohio. 15-36-1G

Clinical Instructor to teach a portion of medical and surgical nursing. School of nursing is enlarging. 7 new faculty positions being added. There will be 33-nurse instructors and 4 Albright professors. 12 instructors in the medical and surgical nursing department and 2 full-time clinical dietitions. Starting salary: $5,820 with increases up to $7,020. Instructors with 2-yr. experience start at $6,180. School has latest teaching aides, including an I.B.M. grading machine. Retirement plan in addition to Social Security, hospital pays the policy. After 3-yr. hospital provides a life insurance policy for employees equivalent to 1-y.r salary, hospital pays the premium. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath and shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities. 1 college in city. 4 universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Pennsylvania. 15-39-4B

Obstetrical Instructor: No administrative responsibilities. Department has 2 obstetrical instructors and has obstetrical supervisor who assists with clinical teaching. School is being enlarged and size of faculty increased. 7 new faculty positions being created. Full accreditation from N.L.N. Large school with no recruitment problem. 33 full-time nurse instructors. Sciences taught by Albright College. Hospital now has 621 beds and is in an expansion program. Entirely new obstetrical department in new building. School has latest teaching aides, including I.B.M. grading machine. Salary: $5,820 with increases to $7,020. Beginning salary: $6,180 for qualified instructor with 2 years teaching experience. Retirement plan in addition to social security. Hospital pays retirement premium. After 3 yr. hospital provides a life insurance policy for the equivalent of 1-yr. salary. Hospital pays the premium. Other liberal personnel policies, attractive working conditions. Each room in nurses' residence has its own private bath and shower. Hospital located in a beautiful 40-acre park. Community has many cultural opportunities including symphonies and museums. 1 college in city. 4 universities have extension center or extension courses in city. Qualifications: Baccalaureate degree with courses in nursing education. Apply: Director of Nurses, The Reading Hospital, Reading, Pennsylvania. 15-39-4A

STAFF NURSES All Clinical Services. Starting salary $382 for day shift; $419 for evening and night shifts, opportunities for advancement. Personnel policies, sick leave, retirement plan, 3-wk. vacation and laundry of uniforms. Orientation and In-service programs. Housing available on Campus. Apply: Director, Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

Staff Nurses, University of Washington 320-bed modern, expanding Teaching and Research Hospital located on campus, offers you an opportunity to join the staff in one of the following specialties: Clinical Research, Premature Center, Open Heart Surgery, Physical Medicine, Orthopedics, Neuro-surgery, Adult and Child Psychiatry in addition to the General Services. Salary: $400-$462. Unique benefit program includes free University courses after six months fulltime employment. For information on opportunities write to: Mrs. Ruth Fine, Director of Nursing Services, University Hospital, 1959 Pacific Avenue, Seattle, Washington. 15-48-2D



NEW HOSPITAL

AJAX, ONTARIO

110 BEDS

Nursing the patient as an individual

Opening — October 1964

VACANCIES for Head Nurses, Assistant Head Nurses, General Duty R.N.'s and Registered Nursing Assistants (Union Agreement for Registered Nursing Assistants) in Medicine and Surgery. O.R., OBS., Pediatrics. Salaries commensurate with prevailing salaries in Metro Toronto. Consideration for experience and education. Overseas nurses welcome. Personnel recognition and excellent fringe benefits. Professional development fostered.

Ajax is 7 miles from Metro Toronto, hourly bus service

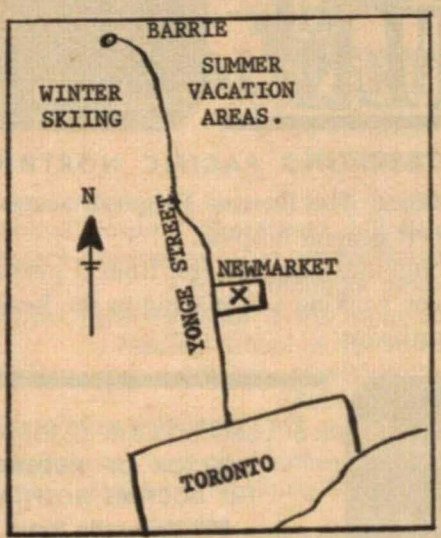
Apply to:

NURSING OFFICE PERSONNEL,

AJAX AND PICKERING GENERAL HOSPITAL,

Ajax, Ontario.

YORK COUNTY HOSPITAL



ONE HOUR FROM DOWNTOWN TORONTO

260 bed Hospital with new facilities including:

INTENSIVE CARE UNIT
SELF CARE UNIT
PSYCHIATRIC UNIT

CLINICAL INSTRUCTRESSES: $385-$460 per month

REGISTERED NURSES: $335-$400 per month

REGISTERED NURSING ASSISTANTS: $230-$265 per month

LIBERAL PERSONNEL BENEFITS INCLUDE:

Pension Plan, Group Life Insurance, Medical and Hospital Insurance. Residence accommodation available.

Please write for further details concerning employment opportunities to:

DIRECTOR OF NURSING, YORK COUNTY HOSPITAL, Newmarket, Ontario.

UNIVERSITY HOSPITAL

UNIVERSITY OF SASKATCHEWAN

Saskatoon, Saskatchewan

CHECK THESE OPPORTUNITIES:

Become part of the team:

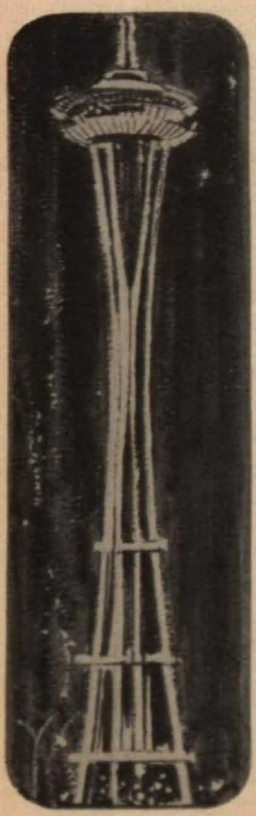
as a graduate nurse
as a team leader
as a nursing assistant

Become part of:

medical unit
surgical unit
pediatric unit
psychiatric unit
obstetrical unit
rehabilitation unit
operating room unit
recovery room unit

Become part of the University Hospital by writing to:

DIRECTOR OF PERSONNEL
UNIVERSITY HOSPITAL, SASKATOON, SASKATCHEWAN



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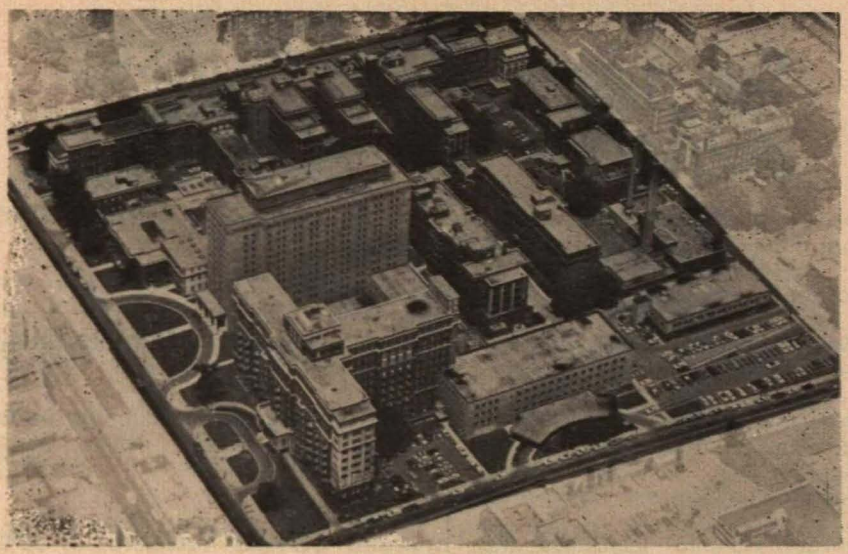
CENTER OF THE EXCITING PACIFIC NORTHWEST

Staff jobs are available at The Doctors Hospital, Seattle, Washington—a 187 bed general hospital.
Excellent salary, congenial atmosphere, liberal personnel policies—you will enjoy working and playing in the beautiful, temperate Pacific Northwest.

For information write or call . . .

DIRECTOR OF NURSING
THE DOCTORS HOSPITAL
909 University Street
Seattle, Washington 98101
Area Code 206
MAin 4-4200, Ext. 233

TORONTO GENERAL HOSPITAL



NURSING OPPORTUNITIES

for

REGISTERED NURSES AND CERTIFIED NURSING ASSISTANTS

Planned Orientation Programme — Inservice Educational Programmes
Opportunity to gain additional knowledge in specialized fields of nursing
Excellent personnel policies
Salaries commensurate with prevailing current salaries in Metropolitan Toronto

For information or application write to:

DIRECTOR OF NURSING, TORONTO GENERAL HOSPITAL,
101 College Street, Toronto 2, Ontario.

ROYAL PERTH HOSPITAL

WESTERN AUSTRALIA

NURSING STAFF

Applications are invited from Registered Nurses to fill vacancies at the above Hospital. Preference will be given to applicants who have had recent experience in an 'acute' hospital and who are prepared to remain for a minimum period of twelve months.

Royal Perth Hospital is the main teaching hospital associated with the Medical School of the University of Western Australia.

Salary and conditions of service are in accordance with the Nurses' (Public Hospitals) Award.

Applications addressed to Matron should include details of age, training, experience, and the names and addresses of two referees, including Matron of Training School. Joseph Griffith, Administrator.

U.S.A.

New York Polyclinic Medical School and Hospital in heart of Manhattan. Six month courses for qualified registered nurses in Operating Room Nursing, and Mediacl Surgical-Out Patient Department Nursing. Classes begin in March and September, include 220 hours of instruction and supervised clinical experience. Room, meals, medical care, and monthly cash stipend. For information write: Director of Nursing Education, 345 West 50th Street, New York, New York 10019 15-33-24

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary for nurses registered in the Province of Ontario $335 monthly with annual increment $10 monthly to $385.

Salary until registration is established — $305 monthly.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days.

Annual sick time 12 days after one year, unused portion cumulative to 36 days.

Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO

THE SARNIA GENERAL HOSPITAL

Offers excellent opportunities for

REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS

Sarnia is an industrial city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a resort area noter for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

The hospital is modern, fully approved (JCAH), and has recently been expanded to 350 beds.

Positions are available in all services.

Salary scale with annual increments to the maximum. Additional salary allowance for two years or more acceptable experience or postgraduate certificate. Benefits include pension plan, 40-hour week, regular rotation of shifts with premium pay for evenings and nights.

Apply:

PERSONNEL DIRECTOR,
SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

for

360-bed accredited General Hospital. Registered Nurses salary range $325 - $377 per month with consideration for contemporary experience or special preparation.

Certified Nursing Assistants $230 - $260 per month.

For further information write:

Director of Nursing Service,
METROPOLITAN GENERAL HOSPITAL,
Windsor, Ontario.

OPERATING ROOM HEAD NURSE

Postgraduate course in Operating Room Technique and Management preferred.

Required for:

225-BED FULLY ACCREDITED HOSPITAL SALARY RANGE: $375 to $420 PLUS RECOGNITION FOR POST-BASIC EDUCATION.

For further information write:

Assistant Director of Nursing (Service),
CORNWALL GENERAL HOSPITAL,
Cornwall, Ontario.

DIRECTOR OF NURSING

at the

STRATFORD GENERAL HOSPITAL

Stratford, Ontario

The Director of Nursing is fully responsible for the Nursing Service, and the School of Nursing through the Director of Nursing Education.

We have just completed an expansion and renovations programme which gives us 209 active treatment beds. All service departments have been modernized and enlarged to take care of another 60 beds when these are required. The old hospital (renovated in 1955) accommodates 105 chronic and convalescent patients.

Excellent personnel policies including membership in the Hospitals of Ontario Pension Plan, Group Life Insurance, and P.S.I. Blue Plan. The hospital is fully accredited.

Applicants who should have their B.Sc. (Nursing) and a wide experience in hospital administration, should address their applications, together with biographical details to:

Mr. J. L. BATEMAN
Superintendent
GENERAL HOSPITAL
Stratford, Ontario

SENIOR NURSES

PUBLIC HEALTH AND HOSPITAL

$4800-$5340
(Nurse 3)

$5520-$6240
(Nurse 4)

PLUS ISOLATION ALLOWANCE AT SOME LOCATIONS

required for

Medical Services
Department of National Health and Welfare
Various Centres Across Canada

The Medical Services Directorate provides interesting and satisfying career opportunities for Public Health and Hospital Nurses.

Qualifications required:

PUBLIC HEALTH NURSING SUPERVISORS—

Current registration as a Nurse in a province of Canada; a certificate in Public Health and either a certificate in Supervision and Teaching or in Nursing Service Administration and at least five years of acceptable experience.

DIRECTOR AND ASSISTANT DIRECTOR OF NURSING—

Current registration as a Nurse in a province of Canada; preferably a certificate in Nursing Service Administration or Supervision and Teaching and at least five years of acceptable experience for positions at the Nurse 4 level and at least four years for positions at the Nurse 3 level.

For further details and application forms, write IMMEDIATELY to:

CIVIL SERVICE COMMISSION OF CANADA, OTTAWA 4,
and ask for Circular 64-593.

SUDBURY ALGOMA SANATORIUM

Requires for New Psychiatric Unit

SUPERVISOR: Postgraduate training and experience in Psychiatry essential. Diploma Course in Teaching and Supervision an asset.

REGISTERED NURSES: With postgraduate training and experience in Psychiatry, for general staff duty.

Salary for both positions commensurate with education and experience.

Apply to:

DIRECTOR OF NURSING,
Sudbury Algoma Sanatorium, Sudbury, Ontario.

Opportunities for Employment Are Available in:

SCHOOL OF NURSING:

CLASSROOM INSTRUCTOR — CLINICAL INSTRUCTORS FOR:
Operating Room, Medicine, Neurosurgery, Pediatrics, Psychiatry.

NURSING SERVICE:

SUPERVISOR, DEPARTMENT OF PEDIATRICS — STAFF NURSES, MEDICINE AND SURGERY.
University teaching hospital. Applicants should be eligible for Ontario Registration.

Personnel policies and further information may be obtained from:

Director of Nursing,
KINGSTON GENERAL HOSPITAL,
Kingston, Ontario.

SCHOOL OF NURSING

METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

requires

INSTRUCTOR IN BASIC SCIENCES AND SURGICAL NURSING

This is an opportunity to participate in the development of a progressive program which emphasizes educational nursing experiences for the student. The program consists of 2 basic, preparatory years followed by one year of Nursing Internship. One class of 32 students is admitted annually.

DUTIES INCLUDE: Instruction in Anatomy and Physiology, Chemistry and Physics. Clinical and Classroom instruction in an integrated program of Medical-Surgical Nursing.

REQUIREMENTS: University preparation in Nursing Education — Salary differential for Degree.

DUTIES TO COMMENCE AUGUST 1, 1964

For further information, contact:

Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario

THE PETERBOROUGH CIVIC HOSPITAL

Requires

CLINICAL INSTRUCTRESS — SURGICAL CLINICAL INSTRUCTRESS — GERIATRICS

EXCELLENT PERSONNEL POLICIES

For further information, write:

THE DIRECTOR OF NURSING,
Peterborough Civic Hospital, Peterborough, Ontario.

GRADUATE STAFF NURSES

Opportunities for men and women on all services including metabolism, rehabilitation, psychiatry, recovery room, medicine, surgery, pediatrics, obstetrics, operating room and emergency room. Well planned orientation and in-service programs, tuition free courses at Western Reserve University after 3 months employment, low cost housing in nurses' residence. Liberal personnel policies with premiums for evening and night tours. Staff Nurse salaries range $400-$440, based on experience and education. For more information ask for our new booklet describing nursing opportunities at University Hospitals.

Write to:

THE DIRECTOR OF NURSING, UNIVERSITY HOSPITALS OF CLEVELAND,
University Circle, Cleveland, Ohio, 44106.

ASSISTANT DIRECTOR

of

NURSING SERVICE

Jeffery Hale's Hospital, Quebec City, is an accredited General Hospital of 161 beds. The School of Nursing has an enrollment of 70. Postgraduate preparation essential.

Write: **Director of Nurses.**

MEDICAL SUPERVISOR REQUIRED:

Position available for Medical Supervisor on a 62-bed unit with two nursing stations. Preference given to applicants with one year University in Ward Administration and experience.

Well defined personnel policies, including pension plan, 4-week vacation, sick time.

Direct inquiries to:

Director of Nursing,
STRATFORD GENERAL HOSPITAL,
Stratford, Ontario.

OSHAWA GENERAL HOSPITAL

Oshawa, Ontario

Requires for School of Nursing

CLINICAL INSTRUCTOR IN SURGICAL NURSING

With Certificate in Nursing Education

For further information, apply to:

DIRECTOR OF NURSING,
Oshawa General Hospital, Oshawa, Ontario.

CLINICAL INSTRUCTORS

ST. JOSEPH'S HOSPITAL, SCHOOL OF NURSING, HAMILTON, ONTARIO

MEDICAL — SURGICAL — and OBSTETRICAL UNITS

Well-equipped modern school of nursing — Expanded January, 1963.
800-Bed Hospital fully accredited. Salary commensurate with preparation and experience.

For further information please apply to:

DIRECTOR OF NURSING,
ST. JOSEPH'S HOSPITAL,
School of Nursing, Hamilton, Ontario.

OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL

OAKVILLE, ONTARIO

General Duty Nurses for all departments, also Operating Room Nurses required in modern 340-bed fully accredited hospital.
Oakville is a progressive community situated on Lake Ontario just twenty miles from the cities of Toronto and Hamilton. Excellent salaries and personnel policies. Further details will be furnished on request.

Apply to:

DIRECTOR OF NURSING,
Oakville-Trafalgar Memorial Hospital,
Oakville, Ontario.

WOODSTOCK GENERAL HOSPITAL

WOODSTOCK, ONTARIO

Applications are invited for the position of Clinical Teacher in Medical-Surgical Unit for **August 1964**.

QUALIFICATIONS:

Prefer degree in Nursing Education and experience or diploma in Nursing Education and minimum of 2 years teaching experience.

Apply:

DIRECTOR OF NURSING,
Woodstock General Hospital,
Woodstock, Ontario.

CLINICAL INSTRUCTORS

Required for School of Nursing in this 350-bed General Hospital. Modern classrooms and facilities. Student enrollment 95.

Minimum qualifications — Diploma in Nursing Education. Good starting salary with special consideration for experience or degree.

Excellent working conditions with opportunities to use progressive techniques in teaching

Apply:

Personnel Director,
SARNIA GENERAL HOSPITAL,
Sarnia, Ontario.

SOUTH PEEL HOSPITAL

COOKSVILLE

A new 450-bed General Hospital, located 12 miles from the City of Toronto, has openings for:

(1) Supervisor for Nursing Office with Nursing Service Administration Diploma.

(2) Supervisor for Unit Administration on Medical Ward.

(3) Head Nurses and Assistant Head Nurses for Medical and Surgical Units.

(4) General Staff Nurses in all departments.

Good personnel policies. Salary commensurate with experience and preparation.

For information or application, write to:

DIRECTOR OF NURSING,
South Peel Hospital,
Cooksville, Ontario.

NURSES

KENORA, ONTARIO

This resort town of 14,000 people has just opened a section of its new 100-bed hospital and in the not too distant future will be opening the second section for which nurses are needed. The hospital is wonderfully located on the shores of beautiful Lake of the Woods in Ontario. In the summer we have activities in swimming, boating, fishing and golfing and in the winter there is skating, curling, tobogganing, skiing and ice fishing.

A nurses' residence is available at a reasonable rate of $20 per month for private room or $15 per month for a double room. Cafeteria services are available at cost as well as a kitchen in the nurses' residence. Separate personnel policies for nurses are available and will be mailed on request.

The starting salary is $330 per month. Eight statutory holidays, sick leave, three weeks vacation with pay are some of the benefits of these policies.

All applications will be treated with courtesy and privacy.

Please apply to:

Director of Nursing,
KENORA GENERAL HOSPITAL,
Kenora, Ontario.

VICTORIAN ORDER OF NURSES FOR CANADA

OFFERS

Interesting and Challenging Careers. Positions are available in various parts of Canada at prevailing salary rates. Good personnel policies. Pension plan. Transportation on duty. Uniform allowance.

Bursaries are offered to assist students in the final year of the basic degree course or graduate nurses taking preparation in public health nursing.

For further information write:

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5 Blackburn Avenue, Ottawa 2, Ontario.

SCHOOL OF NURSING

METROPOLITAN GENERAL HOSPITAL

requires

INSTRUCTOR IN PSYCHIATRIC NURSING

This is an opportunity to participate in the development of a progressive program which emphasizes educational nursing experience for the student. The program consists of 2 basic, preparatory years followed by one year of Nursing Internship. One class of 32 students is admitted annually. **Duties include:** Instruction in Introductory Psychology and Mental Hygiene. Clinical and Classroom Instruction in Psychiatric Nursing. **Requirements:** University preparation in Nursing Education. — Salary differential for Degree. — Duties to commence August, 1964.

For further information, contact:

Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario.

DIRECTOR OF NURSING

FOR MODERN, 163-BED, FULLY ACCREDITED GENERAL HOSPITAL

SALARY COMMENSURATE WITH QUALIFICATIONS AND EXPERIENCE

Please address enquiries to:

Administrator,

KIRKLAND AND DISTRICT HOSPITAL,
Kirkland Lake, Ontario.

REGISTERED NURSES

For General Duty required for 100-bed general hospital. Forty-hour week. Three weeks annual vacation for first three years of service then four weeks annually. Nine (9) statutory holidays annually, 1-1/4 days sick leave per month accumulative to five months. Shift differential of 40 cents for each evening shift and 50 cents for each night shift. Salary range: $315-$390 with special consideration given for postgraduate training and previous experience. Residence accommodation with meals available at the rate of $35 per month if desired.

Apply to:

Director of Nurses,
WEYBURN UNION HOSPITAL,
Weyburn, Saskatchewan.

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Two General Duty Nurses, starting salary $332 - with two years' experience $349 - with four years' experience $366. Travelling expenses paid on completion of one year's service. Personnel policies in accordance with provincial agreement. Health plan and retirement plan in operation. Comfortable nurses' residence. Situated 80 miles upcoast from Vancouver with daily bus and plane connections.

Apply to:

Director of Nursing,
POWELL RIVER GENERAL HOSPITAL,
Powell River, British Columbia.

COLLINGWOOD GENERAL AND MARINE HOSPITAL

Active tourist town on Georgian Bay, requires:

REGISTERED NURSE AS NIGHT SUPERVISOR
REGISTERED NURSE 4-12 SHIFT FOR EMERGENCY AND OPERATING ROOM
REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS FOR GENERAL DUTY

For further information write:

THE DIRECTOR OF NURSING,
Collingwood General and Marine Hospital, Collingwood, Ontario.

ASSISTANT DIRECTOR OF NURSING

REQUIRED FOR

ALBERTA CHILDREN'S HOSPITAL, CALGARY, ALBERTA

Apply to:

Director of Nursing,
ALBERTA CHILDREN'S HOSPITAL, CALGARY, ALBERTA.

MONTREAL CHILDREN'S HOSPITAL

DID YOU KNOW THAT...

1. We have 354 beds for children from the Premature to the Adolescent age group?
2. Our nurses may be bilingual or English-speaking?
3. We are affiliated with McGill University?
4. We have an excellent Orientation and In-Service Program?
5. Salary is commensurate with experience and preparation?
6. We have vacancies for Registered Nurses?

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THE DIRECTOR OF NURSING,
Montreal Children's Hospital, 2300 Tupper Street,
Montreal, Que.

CLINICAL SUPERVISOR, MEDICAL NURSING

A 228-bed General Hospital. Medical Department consists of two 38-bed wards, each with a head nurse in charge.

For information Write to:

Director of Nursing,
JOSEPH BRANT MEMORIAL HOSPITAL,
Burlington, Ontario.

CIVIL SERVICE HEALTH STAFF NURSES

(Nursing Counsellors)
Department of National Health and Welfare, Ottawa, Ontario.
$4,200 - $4,650

Nursing counsellors are required to provide health counselling and guidance to federal government employees.
Qualifications required include registration in a Province of Canada, a diploma or certificate in public health Nursing and at least one year of acceptable nursing experience.

For further information and application forms, write immediately to the:

CIVIL SERVICE COMMISSION OF CANADA, OTTAWA 4, and ask for CIRCULAR 64-594

SUPERINTENDENT OF NURSES

Required by 18-bed Private Hospital. Ontario registration required.
Registered Nurse with supervisory experience or experience as Superintendent of small hospital would fill requirements. Two room apartments with bath and all meals supplied for $20 per month. Four weeks annual vacation per year, eight statutory holidays, hospitalization, medical-surgical and Group Insurance. Moving expenses up to $50 refunded following six months employment. Salary scale will be forwarded following application.

Apply to:

MRS. V. M. SWITZER, SECRETARY,
BOARD OF DIRECTORS, LADY DUNN HOSPITAL, WAWA, ONTARIO.

GENERAL DUTY NURSES

required

For a 220-bed General Hospital in Central Ontario.

Apply to:

MISS B. M. JONES, REG.N.,
Director of Nursing,
Orillia Soldiers' Memorial Hospital,
Orillia, Ontario.

DIRECTOR OF IN-SERVICE EDUCATION

For 200-bed hospital with School of Nursing. University preparation and experience preferred. Salary commensurate with above.

Please apply to:

Director of Nursing,
ST. JOSEPH'S HOSPITAL,
Chatham, Ontario.

ASSISTANT DIRECTOR OF NURSES

PEDIATRIC SUPERVISOR
and
INSTRUCTORS

Applications are now being reviewed for the above positions in a 131-Bed General Hospital with Nursing Assistant Centre.

Apply to:

Director of Nurses,
PARRY SOUND GENERAL HOSPITAL,
Parry Sound, Ontario.

ROYAL JUBILEE HOSPITAL

VICTORIA, B.C.

Invites B.C. Registered Nurses (or those eligible) to apply for these positions:

SUPERVISOR — PSYCHIATRIC NURSING
CHARGE NURSES — OPERATING ROOM
GENERAL STAFF

Apply to:

DIRECTOR OF NURSING.

GENERAL STAFF NURSE POSITIONS

AVAILABLE

In all our Clinical Nursing Services and in the Operating Rooms. Salary commensurate with experience. Opportunities for promotion. Excellent fringe benefits including refund of tuition up to six points per semester.

For further information write:

Director, Nursing Service
THE JOHNS HOPKINS HOSPITAL
Baltimore, Maryland - 21205

THE CENTRAL REGISTRY OF GRADUATE NURSES TORONTO

Furnish Nurses
at any hour
DAY or NIGHT

Telephone: 483-4306

460 Eglinton Avenue East, Suites 301-302
Toronto 12, Ontario
JEAN C. BROWN, REG.N.

ASSISTANT DIRECTOR OF NURSING SERVICE

For accredited 200-bed hospital

QUALIFICATIONS: Baccalaureate Degree preferred. Supervisory experience. Salary according to qualifications. Position open July 1st, 1964.

Apply to:

DIRECTOR OF NURSING,
General Hospital,
Guelph, Ontario.

ST. JOSEPH'S HOSPITAL

Toronto, Ontario

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

600-bed fully accredited hospital provides experience in Operating Room, Recovery Room, Intensive Care Unit, Pediatrics, Orthopedics, Obstetrics, General Surgery and Medicine.

Orientation and Active In-service program for all staff.

Salary is commensurate with preparation and experience.

Benefits include Pension Plan, Group Life Insurance, Sick Leave — 12 days after one year, Ontario Hospital Insurance — 50% payment by hospital.

Rotating Periods of duty — 40 hour week, 8 statutory holidays — annual vacation 3 weeks after one year.

Apply:

ASSISTANT DIRECTOR OF NURSING SERVICE
ST. JOSEPH'S HOSPITAL
30 The Queensway, Toronto 3, Ontario

INSTRUCTORS

1. Clinical Co-ordinator
   (New Position)
2. Clinical Instructors:
   (a) Pediatric Nursing
   (b) Operating Room Nursing
   (c) Surgical Nursing
3. Science Instructors (2):
   University preparation required
   Salary differential for degree

For further information apply to:

Director of Nursing,
BRANDON GENERAL HOSPITAL,
Brandon, Manitoba.

Assistant Head Nurses
General Duty Registered Nurses
AND
Registered Nursing Assistants

REQUIRED FOR

Medical - Surgical - Pediatric Departments

In a 70-bed modern hospital. Excellent employee benefits. Good personnel policies. Located in pleasant community of 11,000 close to Toronto, Hamilton and other large centres.

Address replies to:

Director of Nursing,
GEORGETOWN and DISTRICT
MEMORIAL HOSPITAL,
Georgetown, Ontario.

ST. THOMAS-ELGIN GENERAL HOSPITAL

ST. THOMAS, ONTARIO

Requires

GENERAL DUTY NURSES

Modern 381-bed, fully accredited Hospital Excellent personnel policies, O.H.A. Pension Plan.

Apply:

THE DIRECTOR OF NURSING,
St. Thomas-Elgin General Hospital,
St. Thomas, Ontario.

GENERAL STAFF NURSES

SALARY $415 to $480

(Commensurate w/experience)

$3.00 per day differential for evenings. $1.50 differential for nights. Positions available in Birthroom, Post Partum, Newborn Nursery and Medical - Surgical areas. Time and a half for overtime. Quarters available on hospital grounds. Other liberal fringe benefits.

For more information write:

Personnel Director,
WOMAN'S HOSPITAL,
432 E. Hancock, Detroit 1, Michigan.
TEmple 3-2000

WANTED IMMEDIATELY

Registered Nurses

and

Certified Nursing Assistants

For a new 40-bed Hospital with Nurses' Residence. **Nurses—Salary: $340-$390** according to experience. 3 semi-annual increments of $10 each. **C.N.A.'s—Salary: $225-$255** according to experience. 3 annual increments of $10 each.

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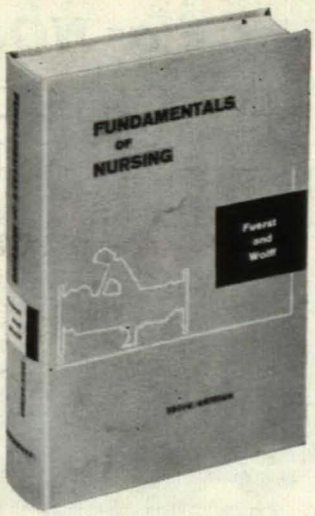

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